BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
LONG-DEI LIU, M.D.	)	Case No. 800-2014-009126
Physician's and Surgeon's	)	
Certificate No. A36134	)	OAH No. 2019010012
	)	
Respondent.	)	
	)	
	)	

DENIAL BY OPERATION OF LAW
PETITION FOR RECONSIDERATION

No action having been taken on the petition for reconsideration, filed by Long-Dei Liu, M.D., and the time for action having expired at 5 p.m. on March 18, 2019, the petition is deemed denied by operation of law.

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	MBC No. 800-2014-009126
LONG-DEI LIU, M.D.	)	
	)	
Physician's and Surgeon's Certificate No. A 36134	)	**ORDER GRANTING STAY**
	)	
	)	(Government Code Section 11521)
	)	
Respondent	)	

Long-Dei Liu, M.D., has filed a Petition for Reconsideration of the Decision in this matter with an effective date of March 8, 2019, at 5:00 p.m.

Execution is stayed until March 18, 2019.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: March 5, 2019

Kimberly Kirchmeyer
Executive Director
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LONG-DEI LIU, M.D., Physician's and Surgeon's License No. A 36134 Respondent.	Case No. 800-2014-009126 OAH No. 2019010012

DECISION AFTER NON-ADOPTION

Laurie R. Pearlman, Administrative Law Judge (ALJ) with the Office of Administrative Hearings, heard this matter on February 12-14 and 20, 2018, and April 10 and 23, 2018, in La Palma, California and Norwalk, California.

Beneth Browne, Deputy Attorney General (DAG), appeared and represented Complainant Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

David Rosenberg and Steven H. Zeigen, Attorneys at Law, appeared and represented Respondent Long-Dei Liu, M.D. (Respondent), who was present.

At the hearing, Complainant's motion to amend the Accusation to delete paragraph 51(a) was granted.

At the conclusion of the hearing, the record was left open for the parties to obtain and lodge the hearing transcript, file Complainant's closing brief (marked for identification as Exhibit 39), Respondent's response brief (marked for identification as Exhibit S), and Complainant's reply brief (marked for identification as Exhibit 40), to submit a request for a protective order sealing confidential records (a sealing order was issued), and to submit a written stipulation (marked for identification as Exhibit 41.) These items were received and the matter was submitted for decision on August 2, 2018.

On October 29, 2018, Panel A of the Board issued an Order of Non-Adoption of Proposed Decision. Oral argument on the matter was heard by the Panel on January 31, 2019, with ALJ Jill Schlichtmann presiding. Complainant was represented by DAG Carr. Respondent was present, and was represented by Steven H. Zeigen, Attorney at Law. Panel A, having read

and considered the entire record, including the transcripts and the exhibits, and having considered the written and oral arguments presented by Respondent and Complainant, hereby makes and enters this decision on the matter.

SUMMARY

Complainant seeks revocation of Respondent's medical certificate on the grounds that he was grossly negligent, committed repeated negligent acts, and demonstrated incompetence in his care and treatment of several obstetrical patients. Complainant presented clear and convincing evidence establishing Respondent's failure to follow the standard of care in each of these cases. Respondent's certificate shall be placed on probation in order to protect the public health and safety.

FACTUAL FINDINGS

Jurisdiction and License History

1. Complainant brought the Accusation in her official capacity. Respondent timely submitted a Notice of Defense.

2. On December 8, 1980, the Board issued to Respondent Physician's and Surgeon's Certificate number A 36134 (certificate). Respondent's certificate is renewed and current with a scheduled expiration date of July 31, 2020.

3. Respondent has been in private practice for nearly 38 years, specializing in obstetrics and gynecology (OB/GYN). He has been a board-certified OB/GYN since the 1980's. Respondent has hospital privileges at Fountain Valley Regional Hospital Medical Center in Fountain Valley, California, and at South Coast Global Medical Center in Santa Ana, California. He has treated more than 10,000 patients in California. No previous discipline has been taken against Respondent's certificate.

Patient P.W.[1]

4. P.W. began prenatal care in China. In November 2014, she became Respondent's patient. Patient P.W. was a 40-year-old Gravida 3 Para 12 female at 31 weeks gestation. At that time, she had gestational diabetes which was controlled by diet. Respondent did not monitor her glucose levels during her pregnancy, nor did he estimate fetal weight during the antenatal course by either ultrasound or clinical examination.

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[1] Initials are used to protect patient privacy.

[2] Gravidity refers to the number of times a female has been pregnant, including the current pregnancy. Para refers to the number of times the pregnancies have been carried to a viable gestational age.

5. On January 21, 2015, at 39 4/7 weeks gestation and in labor, patient P.W. was admitted to Coastal Communities Hospital. At 1:43 p.m., she was 4 centimeters (c.m.) dilated, with spontaneous rupture of the membranes and clear amniotic fluid. Late decelerations were noted.

6. At 2:00 p.m., Respondent was called to evaluate the patient. At 2:05 p.m., an epidural was placed. The fetal monitor strip was noted to be category II with late decelerations that improved with intravenous (IV) fluids, oxygen, and maternal repositioning.

7. At 2:30 p.m., late decelerations recurred. Respondent was notified.

8. At 2:45 p.m., Respondent arrived at patient P.W.'s bedside. At that time, contractions were noted every 1-1.5 minutes consistent with hyper-stimulation and the nurse requested administration of terbutaline, which Respondent denied. Respondent remained at the bedside and placed an internal fetal monitor and intrauterine pressure catheter. Respondent did not estimate fetal weight by either ultrasound or clinical examination.

9. At 3:07 p.m., there were prolonged decelerations with absent variability with the fetal heartrate (FHR) down to 67 to 60 beats per minute (bpm), and the nurse requested that Respondent perform a stat Cesarean section (C-section). Respondent instead opted to perform a vacuum-assisted vaginal delivery because the patient's cervix was rapidly dilating and she was then an anterior rim.

10. Respondent failed to document any discussion with patient P.W. about the specific risks posed by a vacuum-assisted vaginal delivery. These risks included: risks to the baby, given the presence of a declining fetal heartrate, absent variability and prolonged decelerations; risks posed in light of gestational diabetes and his prediction of a "big" baby; the risk of shoulder dystocia;[3] the risk if dilation were slower than anticipated; the risk of the baby receiving abrasions or becoming stuck; the risk of the baby suffering hypoxia; the risk if the vacuum delivery were not successful; the risk if the vacuum delivery were partially attempted, but not successful and the patient were then transferred to an operating room for a C-section and the delay caused; or other risks described in the American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin (Exhibit 37). Likewise, there is no evidence that Respondent informed the patient of the potential benefits of proceeding with the procedure. Nor is there evidence that Respondent described any alternative to the procedure, including proceeding immediately to a C-section delivery, and the risks or benefits of that procedure.

11. At 3:20 p.m., Respondent performed a vacuum-assisted vaginal delivery with a kiwi vacuum over a median episiotomy. The head was delivered and a shoulder dystocia ensued. The fetal heart rate tracing had been noted to be category III and then was not

[3] Shoulder dystocia occurs when a baby's head is delivered through the vagina, but his shoulders get stuck inside the mother's body during a vaginal delivery.

recordable during the 10 minute interval between delivery of the baby's head and delivery of the body.

12. At 3:30 p.m., the infant was delivered with Apgar4 scores of 0/0/2/7. As a result of shoulder dystocia in delivery, the baby was diagnosed with brain hypoxia and right arm nerve injury. The placenta was removed manually, and the episiotomy repaired. Prophylactic antibiotics were given. The estimated blood loss from the delivery is not noted in the medical records.

13. At 4:53 p.m., patient P.W.'s blood pressure (BP) was 81/42 and her heartrate was 157 beats per minute (bpm). At 4:58 p.m., patient P.W.'s blood pressure was 85/66 and her heartrate was 125 bpm. At 5:15 p.m., patient P.W.'s blood pressure was 85/66 and her heartrate was 125 bpm. At 5:40 p.m., heavy bleeding was noted, the uterus was noted to be firm, and there was maternal tachycardia[5] to 120. A large IV was reinserted and Respondent was called.

14. At 6:00 p.m. there was ongoing bleeding. Patient P.W.'s uterus was firm at the umbilicus. Respondent did not perform evaluation for etiologies of blood loss other than uterine atony.[6] Patient P.W.'s blood pressure was 68/52 and her heartrate was 119 bpm. Patient P.W.'s hemoglobin and hematocrit (H/H) platelets were 8.5/26.2/81. Prior to delivery, they had been 11.8/36.9/131. Respondent placed a Bakri balloon and vaginal packing and ordered a transfusion of two units of packed red blood cells (PRBC's). Pitocin and Methergine were administered.[7]

15. At 6:45 p.m., patient P.W.'s blood pressure was 94/55 and her heartrate was 106 bpm. The first unit of PRBC was transfused. Patient P.W. was still bleeding. Although Pitocin and Methergine had been administered, at 6:45 p.m., she was still bleeding. Consent was obtained for surgical vaginal exploration and a possible abdominal hysterectomy. A complete blood panel (CBC) and disseminated intravascular coagulation (DIC)[8] panel were

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[4] Apgar is a quick test typically performed one minute and five minutes after birth. It evaluates a newborn's health on a scale of one to 10, based upon the infant's breathing effort, heart rate, muscle tone, reflexes and skin color.

[5] An abnormally fast resting heart rate.

[6] Uterine atony, or failure of the uterus to contract following delivery, is the most common cause of postpartum hemorrhage.

[7] Pitocin is the brand name of oxytocin, a hormone that stimulates uterine contractions. Methergine is a medicine that works by acting directly on the smooth muscles of the uterus to prevent or control bleeding after giving birth.

[8] Disseminated intravascular coagulation is a serious disorder in which the proteins that control blood clotting become overactive, which can cause massive bleeding.

ordered. Four units of packed red blood cells were ordered, one of which was transfused before surgery. The laboratory test results returned showed H/H/platelets of 10.4/32.4/80; PT 28.2, INR 2.6, PTI 69.7, and fibrinogen <90 consistent with coagulopathy.

16. At 7:18 p.m., patient P.W.'s blood pressure was 95/60 and her heartrate was 118 bpm. A second unit of PRBC's was transfused.

17. At 7:55, patient P.W.'s blood pressure was 117/66 and her heartrate was 106 bpm. The first unit of fresh frozen plasma (FFP) was transfused.

18. At 8:18 p.m., patient P.W. was reported to be pale, with moderate continuous bleeding. The fundus was firm. Respondent administered 800 mcg of rectal Cytotec.[9]

19. Patient P.W. was taken to the operating room (OR) and general anesthesia was administered. Exploration revealed multiple vaginal abrasions near the cervix. These lacerations were the cause of bleeding. These were suture-ligated. A uterine curettage was performed and no products of conception were noted. Avitene and Surgicel were applied, and the estimated blood loss (EBL) was noted as 50 cc. The surgery was completed at 8:25 p.m.

20. At 9:32 p.m., no further bleeding was noted and the patient was transferred to the critical care unit (CCU).

21. Subsequently, another doctor assumed care. A second unit of FFP and additional units of PRBC's were transfused, and one ampule of calcium gluconate was administered. Midday on January 22, 2014, patient P.W. was transferred back to the postpartum floor. She was discharged home the following day with an H/H of 7.9/23.5.

Patient L.N.

22. Patient L.N. was a 26-year-old Gravida 2 Para 1 female with a history of a prior C-section. She began prenatal care in China and first came to see Respondent at 33 weeks' gestation. L.N. had two prenatal visits with Respondent before she presented to the Garden Grove Hospital and Medical Center (Garden Grove Hospital) in labor on March 9, 2014, at 35 5/7 weeks gestation. She was having contractions every three minutes and her cervix was two cm dilated. Respondent performed a repeat C-section that he described as uncomplicated. L.N. was delivered of a healthy infant at 10:19 p.m., the time of birth requested by the patient.

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[9] Cytotec is the brand name for misoprostol, a medication used to prevent stomach ulcers by protecting the stomach lining and decreasing stomach acid secretion. It is also sometimes used to treat ulcers and to induce labor.

23. It was estimated that patient L.N. lost more than 1,000 ml of blood following the Cesarean birth. Respondent was not present in the OR during a significant period of time when bleeding may have been continuing. (Exh. 24, p. 2397.) The anesthesiologist, Gary Kao, M.D., gave the patient Methergine at 10:55 p.m. Patient L.N.'s estimated blood loss from the C-section was 600 cc. At the completion of the C-section, the nurse massaged the uterus and a large gush of blood was observed, about 1,000 cc. The nurse notified Respondent regarding heavy bleeding with clots at 11:00 p.m. Respondent ordered an increase in IV Pitocin, administration of intramuscular (IM) Methergine, Hemabate, and placement of 1,000 mcg of Cytotec per rectum.

24. Patient L.N.'s pre-operative H/H had been 11.2/34.8. At 10:55 p.m., her blood pressure was low at 80/53.

25. At 11:15 p.m., Dr. Kao provided the patient Hemabate IM. At 11:20 p.m., Respondent believed that patient L.N. had responded to the treatment with no further bleeding and her blood pressure had improved. Respondent placed a Bakri postpartum balloon at 11:50 p.m., filled it with 600 cc and packed the vagina. At 11:52 p.m., Respondent ordered a transfusion of four units of PRBCs, which was completed at 12:20 a.m. Respondent provided Cytotec to the patient rectally.

26. During the time of transfusion, patient L.N.'s blood pressure normalized. The DIC labs drawn prior to the blood transfusion were normal. Following the transfusion in the operating room, patient L.N.'s blood pressure was stable, but she remained tachycardic.

27. After the blood transfusion, at 12:32 a.m., patient L.N. was transferred to the intensive care unit (ICU) for observation. At Garden Grove Hospital, labor and delivery patients were routinely placed in the ICU at night, whether they needed ICU-level care or not, because other locations were not available. At this point, patient L.N.'s blood pressure was stable, though she was tachycardic. The Bakri balloon was dislodged during transport, and Peter F. Wang, the assistant surgeon, called Respondent who came and reinserted the balloon at 12:46 a.m., and filled it with 600 cc.

28. At that time, patient L.N. was not bleeding, her uterus was firm and there was no blood in the collection bag of the Bakri balloon. Patient L.N. was awake and talking, her BP was 100/60, and her HR was 120. After the transfusion, at 12:30 a.m., Respondent ordered a CBC and DIC panel, but the order was cancelled by the ICU nurse.

29. At the time Respondent left the hospital, he assumed that Asaad Hakim, M.D., the ICU Intensivist, would be taking over care of patient L.N. Respondent did not speak with Dr. Hakim before leaving the hospital, nor did he delineate responsibility for patient L.N.'s care in his absence. Respondent did not leave any written orders regarding physician responsibility or notification regarding vitals, lab results, or other parameters.

30. Although Respondent believed that Dr. Hakim was the responsible physician, Respondent expected that the nurses would call Respondent if patient L.N.'s H/H was abnormal. Respondent did not directly communicate with the nursing staff in regard to

patient L.N. before he left the hospital.

31. Dr. Hakim, who was not at the hospital, received a call from Dr. Kao, shortly after midnight, with the suggestion that patient L.N. may need to be taken back to the OR for a hysterectomy. Patient L.N. and her mother had reportedly indicated earlier in the day that L.N. wished to retain her uterus and the mother told Respondent that L.N. had a history of postpartum hemorrhage in her prior pregnancy that had been treated by transfusion. Dr. Hakim did not speak with Respondent directly. Dr. Hakim later asserted that he was not the physician responsible for patient L.N.'s care between midnight and 4 a.m.

32. On March 10, 2014, at 1:00 a.m., patient L.N. became hypotensive,[10] she was lethargic with a BP of 90/37, and over the next several hours her condition further deteriorated. No physician was notified during this time.

33. Between 1 a.m. and 2:15 a.m., patient L.N.'s blood pressure dropped precipitously, she became tachycardic, and her lethargy continued.

34. At 3:13 a.m., patient L.N. became bradycardic with a heart rate of 44 bpm. At 3:14 a.m., a code blue was called. Respondent was called at 3:20 a.m. and he returned to the hospital by 3:34 a.m. Patient L.N. was intubated by the ER physician, who placed a central line.

35. Patient L.N.'s labs from 3:05 a.m. showed Hemoglobin (Hb) 4.6, HCT 13.6, platelets 96, PT 10.9, PTI 42. A transfusion of PRBCs and FFP was begun in accordance with the ER physician's recommendations, and a hematologist, Kambiz Afrasiabi, M.D., was consulted for a transfusion. Patient L.N. received Levophed for blood pressure support. Patient L.N.'s PTI returned at greater than 150, consistent with the DIC. Dr. Afrasiabi noted a consumptive coagulopathy due to persistent vaginal bleeding, with exploratory laparotomy recommended to control bleeding and product replacement with PRBC, platelets, cryoprecipitate, FFP, and possible Amicar, an agent to control bleeding.

36. At 4:00 a.m., Dr. Hakim, the ICU physician, arrived. At 4:30 a.m., he noted ongoing vaginal bleeding. He discussed the situation with Respondent who felt patient L.N. was not stable enough to go to the OR for a hysterectomy. Respondent ordered uterine artery embolization, and patient L.N. was sent to interventional radiology for this procedure. That procedure was not completed because the patient suffered a second code blue at 10:00 a.m. At that point Respondent decided to perform a hysterectomy.

37. Respondent noted that there was still some oozing around the Bakri balloon and he performed a supracervical abdominal hysterectomy. Respondent's dictated operative report noted the procedure to be uncomplicated with an EBL of 300 ml. No active bleeding had been noted at the time of the procedure, only serosanguineous fluid. During her ICU stay, patient L.N. received 22 units of PRBCs, nine units of FFP, two units of platelets, and two

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[10] Low blood pressure.

units of cryoprecipitate.

38. At 6:00 p.m., patient L.N. developed abdominal distension with concern for compartment syndrome. A bedside decompression was performed by Dr. Ahn, confirming the diagnosis. Decompression was performed and 1,200 ml of serosanguineous fluid was noted in L.N.'s abdominal cavity at the time of the procedure. Patient L.N. was taken back to the OR by Dr. Ahn for reevaluation due to an elevated LDH and acute renal failure and concern for possible ischemic bowel. This was confirmed at the time of surgery. An exploratory laparotomy, right hemicolectomy, enterectomy of the ileum and multiple enteroenterostomies and procedures to control pelvic bleeding were performed.

39. Patient L.N. developed renal failure and was started on dialysis. Due to patient L.N.'s extremely poor prognosis with persistent shock and anoxic encephalopathy, her family withdrew life support and she passed away at 11:16 p.m. on March 14, 2014. The autopsy reported the cause of death as DIC and multi-organ failure.

Patient X.H.

40. Patient X.H. was a 28-year-old Gravida 1 Para 0 patient at term. She received late prenatal care from Respondent during her first pregnancy beginning at 20 weeks gestation. On May 6, 2014, at 24 weeks gestation, Respondent performed group B Strep testing. An ultrasound at 26 weeks gestation showed a fetus with appropriate growth for the gestational age. At 39 weeks gestation, the recorded fundal height[11] was 35 cm, which would normally raise suspicion for fetal growth restriction. Nevertheless, Respondent stated that he believed the baby was large. Respondent did not note a clinical estimated fetal weight or order an ultrasound despite the lagging fundal height.

41. At 39 3/7 weeks gestation, on August 18, 2014, at 9:30 p.m., patient X.H. had premature rupture of the membranes and arrived at the hospital. Her cervical exam on admission was fingertip dilated, 80 percent effaced and -3 station. Respondent ordered Pitocin administration.

42. When Respondent assessed the patient the next morning at 10:00 a.m., the cervix was still fingertip. Based upon his assessment that patient X.H.'s pelvis was small, the estimated weight of the baby was big (8 pounds), and the baby's head was high, Respondent diagnosed cephalopelvic disproportion and performed a delivery by C-section.

Patient K.B.

43a. Patient K.B. was a pregnant 31-year-old, Gravida 6 female. Respondent provided care and treatment to patient K.B. during her pregnancy. At seven weeks' gestation, on December 13, 2013, Respondent performed group B strep screening.

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[11] Distance from the top of the pubic bone to the top of the uterus measured in centimeters.

43b. Fundal heights were recorded, as follows: 29 weeks, 25 c.m.; 36 weeks, 32 c.m.; 37 weeks, 33 c.m.; and 38 weeks, 33 c.m. Risk factors for fetal growth restriction were present, including lagging fundal heights and a patient who smoked during her pregnancy. Respondent did not assess patient K.B. for fetal growth restriction.

44. On July 15, 2014, Respondent's patient K.B., a pregnant 31 year-old woman at 38 weeks gestation, presented in early labor to Garden Grove Hospital with contractions every two to four minutes. She was dilated 3 cm at presentation. An amniotomy[12] was performed, a fetal scalp electrode and intrauterine pressure catheter were placed, and a fetal bradycardia[13] to 80 bpm was noted at 11:10 p.m. Oxygen and repositioning did not relieve the bradycardia, and at 11:33 p.m. a female infant was delivered by urgent C-section with a weight of 2,750 grams, Apgar scores of 3 and 9, and a nuchal cord times one. The arterial cord pH was 7.056 and base excess -12.8, and the venous cord pH was 7.193 and base excess was -10.9. The infant was admitted to the ICU for slow transition and possible sepsis; a work-up was done and antibiotics were started.

Complainant's Expert Laurie R. Greenberg, M.D.

45. Dr. Greenberg has practiced as an OB/GYN for approximately 30 years. She received her medical degree from the State University of New York, Syracuse College of Medicine in Syracuse, New York, in 1988. She completed a residency in obstetrics and gynecology at the University of California, San Diego, in 1992. Dr. Greenberg has been a board-certified OB/GYN since 1994. Based upon her review of the medical records for each of these patients, and other materials, Dr. Greenberg prepared an expert report, and adopted the findings in her report in her hearing testimony.

Patient P.W.

46. Dr. Greenberg credibly opined that Respondent was grossly negligent, and engaged in repeated negligent acts, in his care and treatment of patient P.W.

47. Dr. Greenberg opined that Respondent committed an extreme departure from the standard of care in that he was grossly negligent because, prior to performing an operative vaginal delivery[14] (using a vacuum), Respondent failed to ensure that patient P.W. met the prerequisites, in that Respondent (a) failed to estimate or document estimating fetal weight; (b) failed to determine or document determining the position of the fetal head, and; (c) failed to obtain informed consent from patient P.W.

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[12] Artificial rupture of membranes.

[13] An abnormally slow resting heart rate.

[14] In a vaginal operative delivery, a physician uses either a vacuum or forceps to achieve a vaginal delivery.

48. Dr. Greenberg based her analysis on ACOG Practice Bulletin Number 154, Operative Vaginal Delivery. (Exh. 13; Exh. 37.) ACOG sets out the prerequisites for operative vaginal delivery, including: determination of the position of the fetal head; performing an estimate of fetal weight, and; the patient has consented to the procedure agreed after being informed of its risks and benefits.

49. Respondent does not dispute that he failed to record an estimate of fetal weight at the hospital. He suggests that it is unnecessary in light of his experience because he can extrapolate weight from fundal height in prenatal records. Dr. Greenberg testified that although fundal height is a way of assessing baby size, weight cannot necessarily be extrapolated. She reiterated that, regardless of how the fetal weight is estimated, the standard of care requires that it be documented at a hospital prior to an operative vaginal delivery. Dr. Greenberg testified that it was particularly important to estimate fetal weight in a patient with gestational diabetes such as patient P.W., since the risks of operative vaginal delivery are increased in that situation. The ACOG Bulletin states that one of the two factors significantly associated with failure of an operative vaginal delivery is increased birth weight. (Exh. 37.)

50. Similarly, Respondent did not assert that he documented the position of the fetal head. Instead, he implies that it is obvious that he knew the baby's position since he used a vacuum and that documenting the position was therefore unnecessary. However, risk associated with fetal head position is so high that operative vaginal delivery is actually "contraindicated if the fetal head is unengaged or the position of the fetal head is unknown." (Exh. 37, p.4.)

51. Dr. Greenberg's testimony that the standard of care requires determination and documentation of estimated fetal weight, and the position of the fetal head is credible and fully supported by ACOG's Practice Bulletin 154 on Operative Vaginal Delivery. (Exh. 37.)

52. The informed consent form that covered the vaginal operative delivery was signed by the patient on January 21, 2015, at 1:40 p.m. (Exh. 16, pp. 28-29.) Dr. Greenberg noted that the patient's circumstances and risk factors had changed substantially between the time patient P.W. signed the form and the time Respondent decided to perform a vacuum assisted vaginal operative delivery and actually began the procedure, after 3:00 p.m.

53. Respondent argued that proper informed consent for the vacuum-assisted operative procedure was established with the patient's signature on a standard informed consent form that included reference to use of a vacuum in the delivery. Dr. Greenberg credibly testified that proper informed consent for the vacuum-assisted delivery in this case required a conversation with patient P.W. (and her husband, if present) at a time close enough to the procedure to enable a discussion of the risks and benefits of the procedure at that specific time, and the alternatives then available, in light of the circumstances then present. That was not done in this instance which, Dr. Greenberg opined, constituted gross negligence.

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54. Dr. Greenberg also credibly opined that Respondent was negligent in his care and treatment of patient P.W. in that he did not assess glucose control in the face of gestational diabetes by failing to: (a) perform glucose surveillance during the pregnancy; (b) estimate fetal weight during the antenatal course by ultrasound or clinical examination; or (c) estimate fetal weight at the time of hospital admission.

55. Dr. Greenberg also credibly opined that Respondent was negligent in his care and treatment of patient P.W. when he failed to appropriately assess and treat the cause of the patient's postpartum hemorrhage (PPH). The ACOG Bulletin regarding PPH (Exh. 35) highlights the significance and seriousness with which PPH must be taken, noting at the outset that it is the "single most significant cause of maternal death worldwide. More than half of all maternal deaths occur within 24 hours of delivery, most commonly from excessive bleeding." (Exh. 35, p. 1.) At the time the ACOG Bulletin was published in October of 2006, an estimated 140,000 women died from PPH each year. (*Id.*) Although there are risk factors for PPH (several of which patient P.W.), PPH can occur without warning and must be an emergency that obstetric practitioners are prepared to manage. Respondent failed to properly consider etiologies other than uterine atony as the cause of P.W.'s PPH. Dr. Greenberg opined that Respondent's failure to follow the ACOG Guidelines in addressing and treating P.W.'s PPH represents a simple departure from the standard of care.

56. Dr. Greenberg opined that Respondent committed a simple departure from the standard of care for his failure to assess glucose control in the face of patient P.W.'s gestational diabetes. Her opinion is based upon the standard of care set forth in ACOG Practice Bulletin 37, Gestational Diabetes Mellitus. (Exh. 13, p. 4; Exh. 37.) As articulated in ACOG Practice Bulletin 137 and in Dr. Greenberg's expert opinion, treatment of gestational diabetes reduces the risk of complications, including shoulder dystocia. Monitoring patients' glucose levels throughout the course of the pregnancy is important to reduce the risks produced by gestational diabetes, yet Dr. Greenberg did not locate in Respondent's records specific documentation of glucose levels. Babies born to women with gestational diabetes are often larger and often have a growth pattern where they have more of a truncal body mass that puts them at increased risk for shoulder distortion, and the attendant risks of nerve injury, lack of oxygen to the baby, and maternal trauma associated with relieving the shoulder dystocia.

Patient L.N.

57. Dr. Greenberg credibly opined that Respondent was grossly negligent, engaged in repeated negligent acts, and demonstrated incompetence in his care and treatment of patient L.N.

58. As with patient P.W., Respondent failed to appropriately assess and manage the underlying cause of patient L.N.'s PPH. Dr. Greenberg opined that this constituted a simple departure from the standard of care.

59. Management of PPH first requires an understanding of the etiology, then an evaluation of the patient consistent with that understanding, and then taking the

appropriate action based on the evaluation. Dr. Greenberg credibly opined that in a case of PPH, a physician must always consider uterine atony, surgical bleeding and coagulopathy as possible causes. Respondent treated patient L.N. for uterine atony only. He used uterotonic agents and a Bakri balloon, but he failed to consider surgical bleeding or coagulopathy as possible alternative causes of patient L.N.'s post-cesarean section hemorrhage. Because Respondent did not consider coagulopathy as a cause of patient L.N.'s PPH, he did not initiate appropriate replacement, consultation, or activation of a hemorrhage protocol for patient L.N.

60. Moreover, Respondent did not explicitly document atony in patient L.N.'s medical record. Respondent noted in the medical record that the gush of blood postpartum was estimated at 1,000 cc, but he did not reference any additional blood loss. Respondent later stated that he expected patient L.N.'s hemoglobin to increase above 10. Respondent's discharge summary noted the cause of DIC was amniotic fluid embolism and PPH, although there was never any suspicion of amniotic fluid embolism prior to, during, or after delivery. Because patient L.N. was not bleeding vaginally, Respondent believed her bleeding was controlled, and he did not consider intraperitoneal bleeding.[15] Dr. Greenberg credibly opined that when hypotension occurs in the face of transfusion, or the rise in the H/H is sub- adequate in the post-operative patient, a physician must consider intraperitoneal bleeding and the underestimation of blood loss.

61. The first Bakri balloon placed by Respondent had fallen out approximately one hour after it was inserted. Although patient L.N. appeared to be stable at the time Respondent left the hospital at 12:52 a.m, the second Bakri balloon had been in place only six minutes at the time Respondent left the hospital. Dr. Greenberg credibly opined that at that time, "either there needed to be observation or a clear care plan as to who was doing that observation." Respondent's failure to directly communicate with other physicians or nursing staff who were assuming the transfer of L.N.'s care constituted a simple departure from the standard of care, according to Dr. Greenberg.

62a. When Respondent left the hospital, he failed to take the necessary steps to ensure there was appropriate follow-up of vital signs and laboratory tests to guide further care of patient L.N. Respondent did not communicate with, consult or collaborate with other health care providers in regard to his patient. Due to L.N.'s critical and complicated medical status, prior to leaving the hospital, the standard of care required that Respondent transfer care by discussing the details of her case and plan of care, and delineate responsibility.

62b. Respondent never spoke with Dr. Hakim, who he believed would assume the care of L.N. There was obvious lack of clarity as to who had continuing responsibility for the patient once Respondent went home. The record did not establish that other providers were given sufficient information by Respondent as to L.N.'s case history and the plan for continuing care, including receipt of blood products, obtaining labs, circumstances in which a

[15] Presence of blood in the peritoneal cavity.

nurse should take action and specific action that should be taken in different circumstances.

63. The communication between Dr. Kao and Dr. Hakim was insufficient. Respondent failed to communicate substantively with other care providers who he contended would be responsible for the patient's care. Respondent did not know the ICU nursing staff and did not commonly admit patients to the ICU. Under these circumstances, clear and careful communication was essential.

64a. Dr. Greenberg credibly opined that in failing to properly manage an unstable patient, Respondent committed an extreme departure from the standard of care and was grossly negligent in the care and treatment of patient L.N. She bases her opinion on ACOG Practice Bulletin Number 76, PPH. There was a lack of appropriate follow-up of vital signs and labs to dictate further care. Respondent ordered uterine artery embolization, which is contraindicated in a patient with unstable vital signs, rather than proceeding with surgical assessment and treatment of L.N.'s bleeding.

64b. Upon Respondent's return to the hospital, both Dr. Afrasiabi and Dr. Hakim, were in favor of L.N. returning to surgery to receive a hysterectomy. However, Respondent chose to perform a uterine artery embolization instead. Because L.N. was unstable, had coded and had ongoing bleeding, Dr. Greenberg credibly opined that L.N. was not a candidate for uterine artery embolization, based upon ACOG Guidelines. Rather, the appropriate care at that point would have been a hysterectomy.

65. Dr. Greenberg credibly opined that Respondent was grossly negligent and committed an extreme departure from the standard of care when, despite a maternal death, he failed to assess potential changes in his practice procedures to improve patient safety. She suggested several changes to his practice that Respondent should have implemented after this incident, but did not. These include improving his communication with nurses and consultants; ensuring that ICU nurses know when he wants to be called; confirming when care of the patient is being transferred to another physician; and ensuring that he continues to responsibly handle all OB-related issues for his patients, even after transfer to the ICU.

66. Subsequent to this incident, Respondent has failed to take steps to ensure prompt consultation with subspecialists and experts in critical situations that are beyond the scope of his usual practice; failed to shift his practice in any other way that might help improve patient safety such as staying in the hospital to facilitate ongoing assessment of a patient who has suffered a major complication; assessing blood loss; activating transfusion protocols for factor replacement; or ensuring that when there is ongoing bleeding in an unstable patient, a hysterectomy is performed without delay.

67. Dr. Greenberg credibly opined that:

A. Respondent was grossly negligent in his care and treatment of patient L.N. in that he inappropriately assessed and managed her postpartum hemorrhage.

B. Respondent was negligent in the care and treatment of patient L.N. in

that he failed to properly manage an unstable patient.

C. Respondent was negligent in his care and treatment of patient L.N. in that he assumed he had transferred care of patient L.N. even though he had had no direct communication with other physicians or nursing staff.

D. Respondent was negligent when, despite a maternal death, he failed to assess potential changes in his practice procedures to improve patient safety.

E. Respondent demonstrated incompetence in that he failed to consider the possibility of consumptive coagulopathy in patient L.N. Respondent also failed to assess coagulopathy, to obtain appropriate replacement of coagulation factors and/or platelets or to activate a hemorrhage protocol. Respondent documented in his dictated discharge summary notes that the cause of DIC was amniotic embolism and PPH, though there was no suspicion of amniotic fluid embolism before, during or after delivery.

F. Respondent demonstrated incompetence in that he failed to consider the possibility of intraperitoneal bleeding in patient L.N. after delivery when she was not bleeding vaginally. Respondent failed to consider that in the post-operative patient, when hypotension occurs in the face of transfusion or the rise in the H/H is subadequate, intraperitoneal bleeding should be considered and underestimation of blood loss should also be considered.

Patient X.H.

68. Dr. Greenberg credibly opined that Respondent engaged in repeated negligent acts in his care and treatment of patient X.H.

69. Respondent was negligent in performing group B Strep screening at approximately 24 weeks gestation rather than between 35 to 37 weeks gestation. This represents a simple departure from the standard of care. Dr. Greenberg based this assertion on ACOG's Committee Opinion on Prevention of Early Onset Group B, Number 485 (Exh. 38.)

70. Respondent was negligent when he failed to estimate fetal weight despite lagging fundal height at 39 weeks gestation. Dr. Greenberg indicated there was no clinical estimated fetal weight noted in the chart, nor did Respondent order an ultrasound. This represents a simple departure from the standard of care. An ultrasound at 26 weeks gestation had shown a fetus with appropriate growth for the gestational age. However, at a prenatal appointment at 39 weeks gestation, Respondent recorded a fundal height of 35 cm. The rate of growth had slowed and the fundal height relative to the gestational age, according to guidelines by ACOG Practice Bulletin, Fetal Growth Restriction, Number 134, placed the fundal height into a category where Respondent needed to obtain the weight of the baby. One simple method of doing so would have been to order an ultrasound. Dr. Greenberg opined that Respondent's failure to order an ultrasound or take other steps to obtain the weight of the baby violated the standard of care and constituted negligence.

Patient K.B.

71. Dr. Greenberg credibly opined that Respondent engaged in repeated negligent acts, in his care and treatment of patient K.B.

72. Respondent was negligent in the care and treatment of patient K.B. when he performed group B Strep screening at approximately seven weeks gestation rather than between 35 to 37 weeks gestation. Dr. Greenberg opined that this was a simple departure from the standard of care.

73. Respondent was negligent in the care and treatment of patient K.B when he failed to assess for fetal growth restriction. Fundal height was lagging in weeks 29, 36, 37 and 38. Dr. Greenberg testified that the records show recorded fundal heights, but no another assessment of fetal weight, despite the lagging fundal heights. The medical chart for patient K.B. does not contain an express assessment for fetal growth restriction by Respondent. Dr. Greenberg credibly opined that this represents a departure from the standard of care. ACOG's Practice Bulletin Number 134 on Fetal Growth Restrictions states that if the number of centimeters of fundal height varies by 3 or more from the number of weeks of gestation, fetal growth restriction should be suspected and an ultrasound should be performed. That guidance was not followed by Respondent. It constituted a simple departure from the standard of care.

Respondent's Expert Denis Tarakjian, M.D.

74. Respondent's expert Dr. Denis Tarakjian, M.D. testified as an expert witness on behalf of Respondent. He graduated from St. George's College of Medicine in Grenada in 1982 and completed an internship and residency at Temple University in 1987. He is board-certified as an OB/GYN and has 35 years of experience in that field. He maintains a full- time practice as an OB/GYN. From 1987 to the present, he has been employed at Sharp Reese Stealy Medical Group and has cared for close to one million OB/GYN patients. Dr. Tarakjian reviewed medical records, investigative reports, declarations and transcripts and opined that Respondent's care and treatment of his patients comported with the standard of care with respect to patients L.N., P.W., X.H. and K.B.

Patient L.N.

75. Dr. Tarakjian opined that Respondent was not negligent in the care and treatment of L.N. in that when there were any issues, Respondent "was there managing them," and the patient was stable when Respondent left the hospital at 12:52 a.m. on March 10, 2014, and transferred over her care.

76. Dr. Tarakjian testified that everything Respondent did in his care and treatment of L.N. comported with ACOG Guidelines, and was well within the standard of care. He noted the medications Respondent gave the patient in an attempt to stop the uterine bleeding were in keeping with ACOG Guidelines, as was his use of a Bakri balloon. Dr. Tarakjian opined that Respondent appropriately gave the patient PRBCs and FFP within the ACOG Guidelines. Dr. Tarakjian noted that there was no blood visualized in the collection device at the time

Respondent replaced the balloon after it dislodged, in accordance with nurse Nguyen's civil testimony that L.N.'s pad was dry and free of blood.

77. Dr. Tarakjian based his determination that patient L.N. was stable when Respondent left the hospital upon the declaration of Dr. Kao (Exhibit E); the civil trial testimony of nurse Nguyen (Exh. A, pp. 542-547); the hearing testimony of Dr. Wang; andRespondent's testimony at hearing. Dr. Tarakjian noted that when Respondent left the hospital, L.N. had exhibited a slightly elevated heart rate, a normal oxygen saturation rate, and stable blood pressures for a lengthy period of time. (Exh. 24 A, p. 61).

78. Dr. Tarakjian opined that because patient L.N. was no longer stable when Respondent returned to the hospital at approximately 3:30 a.m. on March 10, 2014, he reasonably chose not to take L.N. back to surgery after she had coded, based upon Respondent's assessment of risk to the patient. Dr. Tarakjian also stated that Respondent could not have taken the patient to the OR because he would have been unlikely to find an anesthesiologist willing to put L.N. under general anesthesia at that point.

79. Dr. Tarakjian understood that at the time Dr. Liu left the hospital, patient L.N. and her mother were opposed to having him perform a hysterectomy because L.N. wished to have an additional child in the future. He testified that given the patient's stable condition at that time, Respondent properly acted upon his patient's wishes.

80. Dr. Tarakjian opined that L.N.'s death was not attributable to a departure from the standard of care by Respondent. Dr. Tarakjian noted a DIC test Respondent had ordered before he left the hospital had been inexplicably canceled and, prior to 3 a.m., no one from the hospital called Respondent to report that the patient's condition had been deteriorating.

81. Dr. Tarakjian opined that there was nothing Respondent should have done differently with respect to his care and treatment of patient L.N.

82. Dr. Tarakjian's testimony focused on whether or not patient L.N. was stable at the time Respondent left the hospital and immediately upon Respondent's return. He failed to address the issues raised by Dr. Greenberg regarding Respondent's failure to properly manage the patient over time. Respondent argues that he could not take the patient to surgery upon his return because she was not stable, and therefore, he was not negligent. Respondent misconstrues the allegation in this matter. Dr. Greenberg established that Respondent should never have left the patient, given her condition. Had he remained with the patient, he could have stabilized the patient in order to address her issues surgically.

83. Regarding L.N., the Accusation alleges Respondent was grossly negligent in that he failed to properly manage L.N., an unstable patient. Dr. Tarakjian primarily focused on the issue of whether or not Respondent had caused the patient's death. However, that was not alleged in the Accusation. Respondent's failure to manage patient L.N. was alleged and established by clear and convincing evidence.

84. Respondent did not appropriately assess and manage patient's L.N.'s postpartum hemorrhage. Dr. Tarakjian testified as to whether the patient was stable at 12:52 a.m. However, Dr. Greenberg established that in the course of addressing the patient's blood loss, Respondent failed to pursue all of the avenues dictated by ACOG protocol for this presentation. (Exhibit 35.) Respondent only attempted to address the uterine atony. He failed to assess for coagulopathy, which was causing the PPH. This represents, as alleged in the Accusation, a failure to properly manage the patient.

Patient P.W.

85. Dr. Tarakjian reviewed the consent forms signed by patient P.W. He contended that proper informed consent for the vacuum-assisted operative procedure was established with the patient's signature on a standard informed consent form that included reference to use of a vacuum in the delivery. Dr. Tarakjian noted that the standard hospital informed consent forms identified the procedures to be performed, were signed by patient P.W., witnessed by a member of the hospital staff, and signed by Respondent. He deemed that to constitute "adequate" informed consent.

86. Dr. Tarakjian opined that Respondent had not committed gross negligence by failing to estimate, or document that he had estimated, fetal weight. He noted that Respondent had documented both the fundal height and the baby's length. Therefore, in light of Respondent's more than forty years' experience delivering babies, Dr. Tarakjian opined that Respondent would have been able to capably estimate the fetal weight. Dr. Tarakjian relied on the fact that, in this instance, the baby's size was clinically appropriate for gestational age and Respondent had an indication that the baby was in vertex. Dr. Tarakjian stated that if a baby is average for gestational age, physicians do not usually document an estimated fetal weight. They do so only if the baby is disproportionately large or disproportionately small.

87. Dr. Tarakjian opined that Respondent had not committed gross negligence by failing to determine, or document that he had determined, the position of the fetal head. Dr. Tarakjian noted that in performing a vacuum extraction, Respondent had to have made an evaluation of the baby's position in order to know where to place the vacuum. Dr. Tarakjian stated that documenting the position of the fetal head "would seem frivolous because you're really trying to get the baby out and not create a paper trail, per se."

88. Dr. Tarakjian disagreed with the assertions that Respondent was negligent when he failed to assess glucose control, in the case of gestational diabetes, by failing to perform glucose surveillance during P.W.'s pregnancy. Dr. Tarakjian noted that in the patient's chart (Exhibit 17, page 7), Respondent wrote the word "sugar" after the word "urine" for each of her eight visits. Thus, he concluded that Respondent had tested P.W.'s urine for sugar at each visit.

Patient K.B.

89. Dr. Tarakjian disagreed with the assertion that Respondent was negligent in failing to perform the group B strep test at 35 to 37 weeks gestation for patient K.B. He noted

that Respondent did perform the strep test at seven weeks gestation. Since patient K.B was given prophylactic antibiotics at the time of her admission to the hospital, Dr. Tarakjian could not conclude that performing the test on patient K.B. at seven weeks was in error; he simply deemed it to have been "an extra test." He agreed that while the test should optimally be given at 35 to 37 weeks, giving the antibiotics upon admission "would address anything that might have been missed."

90. Dr. Tarakjian disagreed with the assertion that Respondent was negligent in failing to assess patient K.B. for fetal growth restriction. He opined that, in light of Respondent's years of experience as an OB/GYN, Respondent was able to competently assess fetal size because Respondent had been measuring fundal heights throughout patient K.B.'s pregnancy. Moreover, since Respondent had performed multiple ultrasounds on patient K.B., Dr. Tarakjian opined that Respondent had properly assessed fetal growth restriction.

Patient X.H.

91. Dr. Tarakjian disagreed with the assertion that Respondent was negligent in failing to perform a group B strep test for patient X.H. at 35 to 37 weeks gestation. He noted that Respondent did perform the strep test at 24 weeks gestation, although optimally the test should be given at 35 to 37 weeks. As with patient K.B., Dr. Tarakjian opined that since patient X.H. was given prophylactic antibiotics at the time of her admission to the hospital, he did not deem Respondent to have been negligent by committing a departure from the standard of care. Respondent's argument that prophylactic administration upon hospital admission cured the defect is not persuasive in light of Dr. Greenberg's testimony that had the testing been done in accordance with the standard of care, mother and child could have been spared unnecessary antibiotic treatment, which is strongly discouraged.

92. Nor did Dr. Tarakjian believe that Respondent was negligent when he failed to estimate fetal weight despite lagging fundal height at 39 weeks gestation. Based upon ACOG practice bulletin (Q 6 and 7), Dr. Tarakjian opined that measuring the fundal height is only applicable up to 38 weeks. Therefore, he concluded that measuring the fundal height at 39 weeks is of no value.

Respondent's Expert Corey Marco, J.D., M.D.

93. Dr. Marco has 51 years of experience as a physician. He is board-certified as a family practice physician. He graduated summa cum laude from University of California Los Angeles Medical School in 1967 and received his J.D. degree from Stanford Law School in 1975. He served as the Chief of Staff at El Cajon Valley Hospital's ER for two years and is now retired.

94. Dr. Marco opined that when a physician admits a patient to the ICU, typically the patient will be managed by an intensivist with expertise in critical care, rather than by the admitting physician. He has never had privileges at Garden Grove Hospital and has not seen its rules or by-laws. Dr. Marco had not reviewed the entire record in this case, and stated that his

role was simply to testify about the transfer of care when L.N. entered the ICU.

95. Dr. Marco often spoke with the intensivist when one of his patients was transferred to the ICU, but did not do so in every case and opined that such discussions are not always necessary. On "many occasions," Dr. Marco spoke with the ICU nurse if the nurse had questions or if he wanted to check on the patient's status.

Respondent's Evidence

96. Respondent attended China Medical College in Taiwan. He served as an army physician in Taiwan after graduating medical school in 1970. Respondent immigrated to the United States in 1973, and came to California in 1981. He asserted at hearing that he practices medicine because he loves his patients. He still has an active OB/GYN practice, seeing approximately 35 to 40 patients each week. Respondent hopes to practice medicine for another five to 10 years.

97. Respondent contended that all of his actions involving the patients identified in the Accusation comported with ACOG Guidelines. Since the events described in the Accusation, he has taken additional continuing medical education (CME) courses beyond those required for continued licensure, and he completed a medical record-keeping course given by the Physician Assessment and Clinical Education Program (PACE) at the University of California, San Diego.

98. As for patient L.N., Respondent stabilized the patient, making sure her blood pressure was normal and her bleeding had stopped. Respondent spoke to L.N.'s mother, who told him that her daughter did not want a hysterectomy and had experienced PPH after her previous C-section. The mother explained that her daughter now had two sons, but would like to have a girl in the future.

99. Respondent asserted that patient L.N.'s vital signs were stable when he left to go home and he justifiably relied on many other medical professionals who assured him of the patient's stability, including Dr. Kao, Dr. Wang and Nurse Nguyen. Respondent explained that L.N would ordinarily have been sent to the recovery room after her surgery, but because no one covers the recovery room at night, L.N. was transferred to the ICU. Dr. Kao called Dr. Hakim to let him know that L.N. was coming to the ICU.

100. Respondent acknowledged that he remains responsible for all OB-related issues for his patients, even when those patients have been transferred to the ICU. Respondent ordered additional tests to confirm patient L.N. remained stable, but the tests were inexplicably canceled by the ICU nursing staff.

101. When L.N. became hypotensive and began bleeding while in the ICU, the ICU nurse did not contact Respondent, the internist or the intensivist. It was not until patient L.N. coded shortly after 3:00 a.m. on March 10, 2015, that Respondent was called by the ICU nurse. Respondent immediately returned to the hospital, arriving within 14 minutes. Dr. Hakim still was not at the hospital. At the time of Respondent's return, an ER physician was intubating

patients L.N. Respondent testified that the ER doctor and critical care doctor would direct patient L.N.'s care at that point.

102. Two weeks after patient L.N.'s death, Garden Grove Hospital placed Respondent "on a proctoring program" and conducted an investigation. The proctoring monitoring reports were positive (Exhibit P.) At some point, Garden Grove Hospital suspended Respondent's privileges. On October 15, 2015, he took "a leave of absence" and has not returned to Garden Grove Hospital.

103. Respondent argues that he could not take patient L.N. to surgery upon his return because she was not stable, and therefore, he was not negligent. Respondent's focus was on establishing that he did not negligently cause the patient's death by leaving the hospital at 12:52 a.m. or by failing to take the patient to the OR when he returned to the hospital at 3:34 a.m. Respondent misconstrues the allegations in this matter. The focus is not on causation of the tragic death of this patient. Rather, Complainant's focus is whether Respondent's care and treatment of patient L.N. over time conformed to the standard of care.

104. With respect to patients K.B. and X.H., Respondent does not dispute that he did not perform group B strep screening at 35 to 37 weeks' gestation in compliance with the standard of care and ACOG Guidelines. He asserted that providing prophylactic antibiotics at the time of the patients' admission cured the departure. Since these events, Respondent has been performing the Group B Strep test at 35 to 37 weeks.

105. In regard to patient P.W., Respondent did not contend that he recorded an estimate of fetal weight at the hospital. Rather, he suggested that it is not necessary because as an experienced OB/GYN who has delivered over 10,000 babies, he is able to extrapolate fetal weight based upon fundal height information in prenatal records. Similarly, Respondent did not assert that he documented the position of the fetal head. Instead, he implies that it is obvious that he knew the baby's position because he used a vacuum. In addition, Respondent asserts that documenting the baby's position is not necessary because documentation of using a vacuum is sufficient to convey where the fetal head position was. He is emphatic about his position, insisting that the Board's position is "wrong."

Character References

106. Four character witnesses testified at the hearing as to Respondent's skill and quality as a physician and surgeon. They described Respondent as a highly respected member of the medical community who provides quality patient care, and whose knowledge and skills are sought after by a younger generation of physicians. Respondent also submitted declarations from Dr. Kao and Dr. Hong-An Jan, both of which were admitted as administrative hearsay. (Exhs. E and K.)

107. Peter F. Wang, M.D., testified on Respondent's behalf. Dr. Wang, the former Chief of Staff of Garden Grove Hospital, assisted Respondent during L.N.'s surgery. He admitted that he is aware of only portions of the Accusation. Dr. Wang has been licensed in California since 1980 and is a board-certified OB/GYN. Dr. Wang has been a friend of

Respondent for 58 years and has "cross-covered" Respondent's patients for nearly 40 years. He has never received any complaints from patients regarding Respondent. Dr. Wang described Respondent as "very experienced and a good surgeon" who "is an asset to the Orange County medical community." He stated that he has had "no reason to question [Respondent's] judgment. Dr. Wang was the surgeon who assisted Respondent with patient L.N.'s "uneventful" C-section. Dr. Wang stated that to the best of his recollection, when he left the hospital at 11 p.m. that night, patient L.N.'s bleeding had stopped, the patient's vital signs showed she was stable and Respondent handled the patient's bleeding in accordance with "hospital and ACOG hemorrhage protocol." Dr. Wang observed Respondent place the Bakri balloon and opined that no hysterectomy was needed at that time.

108. Thanh Mai Trinh, M.D., testified on Respondent's behalf. She has known him for 18 years and has often assisted him in surgery. Dr. Trinh described Respondent as "very professional," always on-time and honest, with excellent skills. She seeks Respondent's help with "difficult cases." Dr. Trinh testified that Respondent is the "go-to doctor" for other physicians and is does not care whether a patient has insurance coverage. Respondent routinely provides his personal cell phone number to his patients. Dr. Trinh had not seen the Accusation.

109. Annmarie Nguyen, M.D., testified on Respondent's behalf. She has been a board-certified OB/GYN since 1996 and has known Respondent since 1997. Dr. Nguyen was not familiar with the allegations of the Accusation "in detail." She has observed Respondent in surgery "many times" and has never heard any patient complaints about Respondent. Dr. Nguyen testified that Respondent is "well-loved and respected," has an excellent bedside manner, and always takes the time to talk with patients before surgery. She has assisted Respondent in surgery and he often assists her with C-sections, hysterectomies and complicated cases. Respondent is her "first call" because he is "very competent," "extremely helpful" and "always has a way of solving problems."

110. Hyung O. Kim, M.D., testified on Respondent's behalf. He has been a board-certified OB/GYN since 1983. Dr. Kim has known Respondent for 35 or 36 years and has "cross-covered" many cases with him. Dr. Kim has assisted Respondent in surgery one hundred times, and Respondent covered Dr. Kim's practice every Wednesday for over 30 years. Dr. Kim has never heard any patient complaints about Respondent. Respondent has excellent surgical skills and assists Dr. Kim with "tough cases." Dr. Kim has not seen the Accusation and did not have privileges at Garden Grove Hospital when the events of this matter transpired.

Analysis

111. The standard of care for a given profession is a question of fact and in most circumstances must be proven through expert witnesses. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215; see 6 *Witkin, Summary of California Law* (9th Ed.), Torts, sections 749, 750, and 774.) However, in some cases the standard may be defined by a statute or regulation. California law defines "standard of care" as the use of that reasonable

degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. (*Flowers, supra,* 8 Cal. 4th at pp. 997-998.)

112. Dr. Greenberg, Complainant's expert witness, provided credible and persuasive testimony solidly based upon specific references to the pertinent ACOG Guidelines. She did not advocate for one side or the other. Rather, her answers were direct, honest, and thoughtful, without regard to whether or not they helped either party. On the other hand, Respondent's expert, Dr. Tarakjian, justified each of Respondent's actions in the care and treatment of these patients and glossed over Respondent's failure to comply with ACOG Guidelines in providing care and treatment to these women. The testimony of Respondent's expert, Dr. Marco, was limited solely to the issue of patient L.N.'s transfer to the ICU. Since he had no experience at Garden Grove Hospital and was not familiar with its procedures, his testimony was accorded little weight.

LEGAL CONCLUSIONS.

1. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), for gross negligence in relation to his care and treatment of patients P.W. and L.N., as set forth in Factual Findings 4-39; 45-67; and 111-112.

2. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), for repeated negligent acts in relation to his care and treatment of patients P.W., L.N., X.H. and K.B., as set forth in Factual Findings 4-73 and 111-112.

3. Cause exists to discipline Respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (d), in that he demonstrated incompetence in relation to his care and treatment patient L.N., as set forth in Factual Findings 22-39; 57-67; and 111-112.

The Applicable Law

4. The standard of proof which must be met to establish the charging allegations herein is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests with Complainant to offer proof that is clear, explicit and unequivocal-- so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

5. The purpose of the Medical Practice Act[16] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty

[16] Business and Professions Code section 2000, et seq.

of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App. 3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

6. "The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.)" (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

7. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); and (d) incompetence.

8. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

9. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

10. Incompetence has been defined as a "general lack of present ability to perform a given duty as distinguished from inability to perform such duty as a result of mere neglect or omission." (*Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 837-838.) "[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty." (*Id.* at p. 838.)

11. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a

manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

Appropriate Level of Discipline

12. Complainant seeks revocation of Respondent's certificate. While revocation falls into the range of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, particularly when gross negligence is involved, such discipline is not warranted in this matter. Respondent has enjoyed a long period of practice with no prior record of discipline, and he is well-regarded in the medical community.

13. The minimum period of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders* is five years' probation for the types of violations established in this matter. The purpose of a disciplinary action such as this one, however, is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) Although he disagrees with Complainant's charges, Respondent has started to take corrective action to improve his practice and patient safety. In this case, the public would be adequately protected by the imposition of a 35-month period of probation, with specific terms and conditions that will assist in Respondent's rehabilitation.

ORDER

Certificate No. A 36134 issued to Respondent Long-Dei Lui, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for 35 months, upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents

that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Monitoring – Practice

Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to

cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

4. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true and correct copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

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6. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. General Probation Requirements

Compliance with Probation Unit:

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes:

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice:

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal:

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California:

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

12. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

The Decision shall become effective at 5:00 p.m. on March 8, 2019

IT IS SO ORDERED this 7th day of February 2019.

Ronald H. Lewis, M.D., Chair
Panel A
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	
	)	
LONG-DEI LIU, M.D.	)	Case No.: 800-2014-009126
	)	
Physician's & Surgeon's Certificate No: A36134	)	OAH No.: 2017061261
	)	
	)	
Respondent	)	
	)	

ORDER OF NON-ADOPTION
OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed at whether the level of discipline ordered is sufficient to protect the public. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Jilio-Ryan Court Reporters, 14661 Franklin Ave., #150, Tustin, CA 92780. The telephone number is (714) 424-9902.

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-8906
Attention: Richard M. Acosta

Date: October 29, 2018

Ronald Lewis, M.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LONG-DEI LIU, M.D., Physician's and Surgeon's License No. A 36134 Respondent.	Case No. 800-2014-009126 OAH No. 2017061261

PROPOSED DECISION

Laurie R. Pearlman, Administrative Law Judge with the Office of Administrative Hearings, heard this matter on February 12-14 and 20, 2018, and April 10 and 23, 2018, in La Palma, California and Norwalk, California.

Beneth Browne, Deputy Attorney General, appeared and represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

David Rosenberg and Steven H. Zeigen, Attorneys at Law, appeared and represented respondent Long- Dei Liu, M.D., who was present.

At the hearing, complainant's motion to amend the Accusation to delete paragraph 51(a) was granted.

At the conclusion of the hearing, the record was left open for the parties to obtain and lodge the hearing transcript, file complainant's closing brief (marked for identification as Exhibit 39), respondent's response brief (marked for identification as Exhibit S), and complainant's reply brief (marked for identification as Exhibit 40), to submit a request for a protective order sealing confidential records (a sealing order was issued), and to submit a written stipulation (marked for identification as Exhibit 41.) These items were received and the matter was submitted for decision on August 2, 2018.

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SUMMARY

Complainant seeks revocation of respondent's medical certificate on the grounds that he was grossly negligent, committed repeated negligent acts, and demonstrated incompetence in his care and treatment of several obstetrical patients. Complainant presented clear and convincing evidence establishing respondent's failure to follow the standard of care in each of these cases. Respondent's certificate shall be placed on probation in order to protect the public health and safety.

FACTUAL FINDINGS

Jurisdiction and License History

1. Complainant brought the Accusation in her official capacity. Respondent timely submitted a Notice of Defense.

2. On December 8, 1980, the Board issued to respondent Physician's and Surgeon's Certificate number A 36134 (certificate). Respondent's certificate is renewed and current with a scheduled expiration date of July 31, 2020.

3. Respondent has been in private practice for nearly 38 years, specializing in obstetrics and gynecology (OB/GYN). He has been a Board-certified OB/GYN since the 1980's. Respondent has hospital privileges at Fountain Valley Regional Hospital Medical Center in Fountain Valley, California, and at South Coast Global Medical Center in Santa Ana, California. He has treated more than 10,000 patients in California. No previous discipline has been taken against respondent's certificate.

Patient P.W.[1]

4. P.W. began prenatal care in China. In November of 2014, she became respondent's patient. Patient P.W. was a 40 year-old Gravida 3 Para 1[2] female at 31 weeks gestation. At that time, she had gestational diabetes which was controlled by diet. Respondent did not monitor her glucose levels during her pregnancy, nor did he estimate fetal weight during the antenatal course by either ultrasound or clinical examination.

5. On January 21, 2015, at 39 4/7 weeks gestation and in labor, patient P.W. was admitted to Coastal Communities Hospital. At 1:43 p.m., she was 4 centimeters (c.m.)

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[1] Initials are used to protect patient privacy.

[2] Gravidity refers to the number of times a female has been pregnant, including the current pregnancy. Para refers to the number of times the pregnancies have been carried to a viable gestational age.

dilated, with spontaneous rupture of the membranes and clear amniotic fluid. Late decelerations were noted.

6. At 2:00 p.m., respondent was called to evaluate the patient. At 2:05 p.m., an epidural was placed. The fetal monitor strip was noted to be category II with late decelerations that improved with intravenous (IV) fluids, oxygen, and maternal repositioning.

7. At 2:30 p.m., late decelerations recurred. Respondent was notified.

8. At 2:45 p.m., respondent arrived at patient P.W.'s bedside. At that time, contractions were noted every 1-1.5 minutes consistent with hyper-stimulation and the nurse requested administration of terbutaline, which respondent denied. Respondent remained at the bedside and placed an internal fetal monitor and intrauterine pressure catheter. Respondent did not estimate fetal weight by either ultrasound or clinical examination.

9. At 3:07 p.m., there were prolonged decelerations with absent variability with the fetal heartrate (FHR) down to 67 to 60 beats per minute (bpm), and the nurse requested that respondent perform a stat Cesarean section (C-section). Respondent instead opted to perform a vacuum-assisted vaginal delivery because the patient's cervix was rapidly dilating and she was then an anterior rim.

10. Respondent failed to document any discussion with patient P.W. about the specific risks posed by a vacuum-assisted vaginal delivery. These risks included: risks to the baby, given the presence of a declining fetal heartrate, absent variability and prolonged decelerations; risks posed in light of gestational diabetes and his prediction of a "big" baby; the risk of shoulder dystocia;[3] the risk if dilation were slower than anticipated; the risk of the baby receiving abrasions or becoming stuck; the risk of the baby suffering hypoxia; the risk if the vacuum delivery were not successful; the risk if the vacuum delivery were partially attempted, but not successful and the patient were then transferred to an operating room for a C-section and the delay caused; or other risks described in the American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin (Exhibit 37). Likewise, there is no evidence that respondent informed the patient of the potential benefits of proceeding with the procedure. Nor is there evidence that respondent described any alternative to the procedure, including proceeding immediately to a C-section delivery, and the risks or benefits of that procedure.

11. At 3:20 p.m., respondent performed a vacuum-assisted vaginal delivery with a kiwi vacuum over a median episiotomy. The head was delivered and a shoulder dystocia ensued. The fetal heart rate tracing had been noted to be category III and then was not recordable during the 10 minute interval between delivery of the baby's head and delivery of the body.

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[3] Shoulder dystocia occurs when a baby's head is delivered through the vagina, but his shoulders get stuck inside the mother's body during a vaginal delivery.

12. At 3:30 p.m., the infant was delivered with Apgar[4] scores of 0/0/2/7. As a result of shoulder dystocia in delivery, the baby was diagnosed with brain hypoxia and right arm nerve injury. The placenta was removed manually, and the episiotomy repaired. Prophylactic antibiotics were given. The estimated blood loss from the delivery is not noted in the medical records.

13. At 4:53 p.m., patient P.W.'s blood pressure (BP) was 81/42 and her heartrate was 157 beats per minute (bpm). At 4:58 p.m., patient P.W.'s blood pressure was 85/66 and her heartrate was 125 bpm. At 5:15 p.m., patient P.W.'s blood pressure was 85/66 and her heartrate was 125 bpm. At 5:40 p.m., heavy bleeding was noted, the uterus was noted to be firm, and there was maternal tachycardia[5] to 120. A large IV was reinserted and respondent was called.

14. At 6:00 p.m. there was ongoing bleeding. Patient P.W.'s uterus was firm at the umbilicus. Respondent did not perform evaluation for etiologies of blood loss other than uterine atony.[6] Patient P.W.'s blood pressure was 68/52 and her heartrate was 119 bpm. Patient P.W.'s hemoglobin and hematocrit (H/H) platelets were 8.5/26.2/81. Prior to delivery, they had been 11.8/36.9/131. Respondent placed a Bakri balloon and vaginal packing and ordered a transfusion of two units of packed red blood cells (PRBC's). Pitocin and Methergine were administered.[7]

15. At 6:45 p.m., patient P.W.'s blood pressure was 94/55 and her heartrate was 106 bpm. The first unit of PRBC was transfused. Patient P.W. was still bleeding. Although Pitocin and Methergine had been administered, at 6:45 p.m., she was still bleeding. Consent was obtained for surgical vaginal exploration and a possible abdominal hysterectomy. A complete blood panel (CBC) and disseminated intravascular coagulation (DIC)[8] panel were ordered. Four units of packed red blood cells were ordered, one of which was transfused before surgery. The laboratory test results returned showed H/H/platelets of 10.4/32.4/80; PT 28.2, INR 2.6, PTI 69.7, and fibrinogen <90 consistent with coagulopathy.

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[4] Apgar is a quick test typically performed one minute and five minutes after birth. It evaluates a newborn's health on a scale of one to 10, based upon the infant's breathing effort, heart rate, muscle tone, reflexes and skin color.

[5] An abnormally fast resting heart rate.

[6] Uterine atony, or failure of the uterus to contract following delivery, is the most common cause of postpartum hemorrhage.

[7] Pitocin is the brand name of oxytocin, a hormone that stimulates uterine contractions. Methergine is a medicine that works by acting directly on the smooth muscles of the uterus to prevent or control bleeding after giving birth.

[8] Disseminated intravascular coagulation is a serious disorder in which the proteins that control blood clotting become overactive, which can cause massive bleeding.

16. At 7:18 p.m., patient P.W.'s blood pressure was 95/60 and her heartrate was 118 bpm. A second unit of PRBC's was transfused.

17. At 7:55, patient P.W.'s blood pressure was 117/66 and her heartrate was 106 bpm. The first unit of fresh frozen plasma (FFP) was transfused.

18. At 8:18 p.m., patient P.W. was reported to be pale, with moderate continuous bleeding. The fundus was firm. Respondent administered 800 mcg of rectal Cytotec.[9]

19. Patient P.W. was taken to the operating room (OR) and general anesthesia was administered. Exploration revealed multiple vaginal abrasions near the cervix. These lacerations were the cause of bleeding. These were suture-ligated. A uterine curettage was performed and no products of conception were noted. Avitene and Surgicel were applied, and the estimated blood loss (EBL) was noted as 50 cc. The surgery was completed at 8:25 p.m.

20. At 9:32 p.m., no further bleeding was noted and the patient was transferred to the critical care unit (CCU).

21. Subsequently, another doctor assumed care. A second unit of FFP and additional units of PRBC's were transfused, and one ampule of calcium gluconate was administered. Midday on January 22, 2014, patient P.W. was transferred back to the postpartum floor. She was discharged home the following day with an H/H of 7.9/23.5.

Patient L.N.

22. Patient L.N. was a 26 year-old Gravida 2 Para 1 female with a history of a prior C-section. She began prenatal care in China and first came to see respondent at 33 weeks' gestation. L.N. had two prenatal visits with respondent before she presented to the Garden Grove Hospital and Medical Center (Garden Grove Hospital) in labor on March 9, 2014, at 35 5/7 weeks gestation. She was having contractions every three minutes and her cervix was two cm dilated. Respondent performed a repeat C-section that he described as uncomplicated. L.N. was delivered of a healthy infant at 10:19 p.m., the time of birth requested by the patient.

23. It was estimated that patient L.N. lost more than 1,000 ml of blood following the Cesarean birth. Respondent was not present in the OR during a significant period of time when bleeding may have been continuing. (Exh. 24, p. 2397.) The anesthesiologist, Gary Kao, M.D., gave the patient Methergine at 10:55 p.m. Patient L.N.'s estimated blood loss from the C-section was 600 cc. At the completion of the C-section, the nurse massaged the uterus and a large gush of blood was observed, about 1,000 cc. The nurse notified respondent regarding heavy bleeding with clots at 11:00 p.m. Respondent ordered an

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[9] Cytotec is the brand name for misoprostol, a medication used to prevent stomach ulcers by protecting the stomach lining and decreasing stomach acid secretion. It is also sometimes used to treat ulcers and to induce labor.

increase in IV Pitocin, administration of intramuscular (IM) Methergine, Hemabate, and placement of 1,000 mcg of Cytotec per rectum.

24. Patient L.N.'s pre-operative H/H had been 11.2/34.8. At 10:55 p.m., her blood pressure was low at 80/53.

25. At 11:15 p.m., Dr. Kao provided the patient Hemabate IM. At 11:20 p.m., respondent believed that patient L.N. had responded to the treatment with no further bleeding and her blood pressure had improved. Respondent placed a Bakri postpartum balloon at 11:50 p.m., filled it with 600 cc and packed the vagina. At 11:52 p.m., respondent ordered a transfusion of four units of PRBCs, which was completed at 12:20 a.m. Respondent provided Cytotec to the patient rectally.

26. During the time of transfusion, patient L.N.'s blood pressure normalized. The DIC labs drawn prior to the blood transfusion were normal. Following the transfusion in the operating room, patient L.N.'s blood pressure was stable, but she remained tachycardic.

27. After the blood transfusion, at 12:32 a.m., patient L.N. was transferred to the intensive care unit (ICU) for observation. At Garden Grove Hospital, labor and delivery patients were routinely placed in the ICU at night, whether they needed ICU-level care or not, because other locations were not available. At this point, patient L.N.'s blood pressure was stable, though she was tachycardic. The Bakri balloon was dislodged during transport, and Peter F. Wang, the assistant surgeon, called respondent who came and reinserted the balloon at 12:46 a.m., and filled it with 600 cc.

28. At that time, patient L.N. was not bleeding, her uterus was firm and there was no blood in the collection bag of the Bakri balloon. Patient L.N. was awake and talking, her BP was 100/60, and her HR was 120. After the transfusion, at 12:30 a.m., respondent ordered a CBC and DIC panel, but the order was cancelled by the ICU nurse.

29. At the time respondent left the hospital, he assumed that Asaad Hakim, M.D., the ICU Intensivist, would be taking over care of patient L.N. Respondent did not speak with Dr. Hakim before leaving the hospital, nor did he delineate responsibility for patient L.N.'s care in his absence. Respondent did not leave any written orders regarding physician responsibility or notification regarding vitals, lab results, or other parameters.

30. Although respondent believed that Dr. Hakim was the responsible physician, respondent expected that the nurses would call respondent if patient L.N.'s H/H was abnormal. Respondent did not directly communicate with the nursing staff in regard to patient L.N. before he left the hospital.

31. Dr. Hakim, who was not at the hospital, received a call from Dr. Kao, shortly after midnight, with the suggestion that patient L.N. may need to be taken back to the OR for a hysterectomy. Patient L.N. and her mother had reportedly indicated earlier in the day that L.N. wished to retain her uterus and the mother told respondent that L.N. had a history of postpartum hemorrhage in her prior pregnancy that had been treated by transfusion. Dr.

Hakim did not speak with respondent directly. Dr. Hakim later asserted that he was not the physician responsible for patient L.N.'s care between midnight and 4 a.m.

32. On March 10, 2014 at 1:00 a.m., patient L.N. became hypotensive,[10] she was lethargic with a BP of 90/37, and over the next several hours her condition further deteriorated. No physician was notified during this time.

33. Between 1 a.m. and 2:15 a.m., patient L.N.'s blood pressure dropped precipitously, she became tachycardic, and her lethargy continued.

34. At 3:13 a.m., patient L.N. became bradycardic with a heart rate of 44 bpm. At 3:14 a.m., a code blue was called. Respondent was called at 3:20 a.m. and he returned to the hospital by 3:34 a.m. Patient L.N. was intubated by the ER physician, who placed a central line.

35. Patient L.N.'s labs from 3:05 a.m. showed Hemoglobin (Hb) 4.6, HCT 13.6, platelets 96, PT 10.9, PTI 42. A transfusion of PRBCs and FFP was begun in accordance with the ER physician's recommendations, and a hematologist, Kambiz Afrasiabi, M.D., was consulted for a transfusion. Patient L.N. received Levophed for blood pressure support. Patient L.N.'s PTI returned at greater than 150, consistent with the DIC. Dr. Afrasiabi noted a consumptive coagulopathy due to persistent vaginal bleeding, with exploratory laparotomy recommended to control bleeding and product replacement with PRBC, platelets, cryoprecipitate, FFP, and possible Amicar, an agent to control bleeding.

36. At 4:00 a.m., Dr. Hakim, the ICU physician, arrived. At 4:30 a.m., he noted ongoing vaginal bleeding. He discussed the situation with respondent who felt patient L.N. was not stable enough to go to the OR for a hysterectomy. Respondent ordered uterine artery embolization, and patient L.N. was sent to interventional radiology for this procedure. That procedure was not completed because the patient suffered a second code blue at 10:00 a.m. At that point respondent decided to perform a hysterectomy.

37. Respondent noted that there was still some oozing around the Bakri balloon and he performed a supracervical abdominal hysterectomy. Respondent's dictated operative report noted the procedure to be uncomplicated with an EBL of 300 ml. No active bleeding had been noted at the time of the procedure, only serosanguineous fluid. During her ICU stay, patient L.N. received 22 units of PRBCs, nine units of FFP, two units of platelets, and two units of cryoprecipitate.

38. At 6:00 p.m., patient L.N. developed abdominal distension with concern for compartment syndrome. A bedside decompression was performed by Dr. Ahn, confirming the diagnosis. Decompression was performed and 1,200 ml of serosanguineous fluid was noted in L.N.'s abdominal cavity at the time of the procedure. Patient L.N. was taken back to the OR by Dr. Ahn for reevaluation due to an elevated LDH and acute renal failure and concern for possible ischemic bowel. This was confirmed at the time of surgery. An

[10] Low blood pressure.

exploratory laparotomy, right hemicolectomy, enterectomy of the ileum and multiple enteroenterostomies and procedures to control pelvic bleeding were performed.

39. Patient L.N. developed renal failure and was started on dialysis. Due to patient L.N.'s extremely poor prognosis with persistent shock and anoxic encephalopathy, her family withdrew life support and she passed away at 11:16 p.m. on March 14, 2014. The autopsy reported the cause of death as DIC and multi-organ failure.

Patient X.H.

40. Patient X.H. was a 28 year-old gravida 1 para 0 patient at term. She received late prenatal care from respondent during her first pregnancy beginning at 20 weeks gestation. On May 6, 2014, at 24 weeks gestation, respondent performed group B Strep testing. An ultrasound at 26 weeks gestation showed a fetus with appropriate growth for the gestational age. At 39 weeks gestation, the recorded fundal height[11] was 35 cm, which would normally raise suspicion for fetal growth restriction. Nevertheless, respondent stated that he believed the baby was large. Respondent did not note a clinical estimated fetal weight or order an ultrasound despite the lagging fundal height.

41. At 39 3/7 weeks gestation, on August 18, 2014 at 9:30 p.m., patient X.H. had premature rupture of the membranes and arrived at the hospital. Her cervical exam on admission was fingertip dilated, 80 percent effaced and -3 station. Respondent ordered Pitocin administration.

42. When Respondent assessed the patient the next morning at 10:00 a.m., the cervix was still fingertip. Based upon his assessment that patient X.H.'s pelvis was small, the estimated weight of the baby was big (8 pounds), and the baby's head was high, respondent diagnosed cephalopelvic disproportion and performed a delivery by C-section.

Patient K.B.

43a. Patient K.B. was a pregnant 31 year-old, gravida 6. Respondent provided care and treatment to patient K.B. during her pregnancy. At seven weeks' gestation, on December 13, 2013, respondent performed group B strep screening.

43b. Fundal heights were recorded, as follows: 29 weeks, 25 c.m.; 36 weeks, 32 c.m.; 37 weeks, 33 c.m.; and 38 weeks, 33 c.m. Risk factors for fetal growth restriction were present, including lagging fundal heights and a patient who smoked during her pregnancy. Respondent did not assess patient K.B. for fetal growth restriction.

44. On July 15, 2014, respondent's patient K.B., a pregnant 31 year-old woman at 38 weeks gestation, presented in early labor to Garden Grove Hospital with contractions

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[11] Distance from the top of the pubic bone to the top of the uterus measured in centimeters.

every two to four minutes. She was dilated 3 cm at presentation. An amniotomy[12] was performed, a fetal scalp electrode and intrauterine pressure catheter were placed, and a fetal bradycardia[13] to 80 bpm was noted at 11:10 p.m. Oxygen and repositioning did not relieve the bradycardia, and at 11:33 p.m. a female infant was delivered by urgent C-section with a weight of 2,750 grams, Apgar scores of 3 and 9, and a nuchal cord times one. The arterial cord pH was 7.056 and base excess -12.8, and the venous cord pH was 7.193 and base excess was -10.9. The infant was admitted to the ICU for slow transition and possible sepsis; a work-up was done and antibiotics were started.

Complainant's Expert Laurie R. Greenberg, M.D.

45. Dr. Greenberg has practiced as an OB/GYN for approximately 30 years. She received her medical degree from the State University of New York, Syracuse College of Medicine in Syracuse, New York, in 1988. She completed a residency in obstetrics and gynecology at the University of California, San Diego, in 1992. Dr. Greenberg has been a Board-certified OB/GYN since 1994. Based upon her review of the medical records for each of these patients, and other materials, Dr. Greenberg prepared an expert report, and adopted the findings in her report in her hearing testimony.

Patient P.W.

46. Dr. Greenberg credibly opined that respondent was grossly negligent, and engaged in repeated negligent acts, in his care and treatment of patient P.W.

47. Dr. Greenberg opined that respondent committed an extreme departure from the standard of care in that he was grossly negligent because, prior to performing an operative vaginal delivery[14] (using a vacuum), respondent failed to ensure that patient P.W. met the prerequisites, in that respondent (a) failed to estimate or document estimating fetal weight; (b) failed to determine or document determining the position of the fetal head, and; (c) failed to obtain informed consent from patient P.W.

48. Dr. Greenberg based her analysis on ACOG Practice Bulletin Number 154, Operative Vaginal Delivery. (Exh. 13; Exh. 37.) ACOG sets out the prerequisites for operative vaginal delivery, including: determination of the position of the fetal head; performing an estimate of fetal weight, and; the patient has consented to the procedure agreed after being informed of its risks and benefits.

49. Respondent does not dispute that he failed to record an estimate of fetal weight at the hospital. He suggests that it is unnecessary in light of his experience because he can

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[12] Artificial rupture of membranes.

[13] An abnormally slow resting heart rate.

[14] In a vaginal operative delivery, a physician uses either a vacuum or forceps to achieve a vaginal delivery.

extrapolate weight from fundal height in prenatal records. Dr. Greenberg testified that although fundal height is a way of assessing baby size, weight cannot necessarily be extrapolated. She reiterated that, regardless of how the fetal weight is estimated, the standard of care requires that it be documented at a hospital prior to an operative vaginal delivery. Dr. Greenberg testified that it was particularly important to estimate fetal weight in a patient with gestational diabetes such as patient P.W., since the risks of operative vaginal delivery are increased in that situation. The ACOG Bulletin states that one of the two factors significantly associated with failure of an operative vaginal delivery is increased birth weight. (Exh. 37.)

50. Similarly, respondent did not assert that he documented the position of the fetal head. Instead, he implies that it is obvious that he knew the baby's position since he used a vacuum and that documenting the position was therefore unnecessary. However, risk associated with fetal head position is so high that operative vaginal delivery is actually "contraindicated if the fetal head is unengaged or the position of the fetal head is unknown." (Exh. 37, p.4.)

51. Dr. Greenberg's testimony that the standard of care requires determination and documentation of estimated fetal weight, and the position of the fetal head is credible and fully supported by ACOG's Practice Bulletin 154 on Operative Vaginal Delivery. (Exh. 37.)

52. The informed consent form that covered the vaginal operative delivery was signed by the patient on January 21, 2015, at 1:40 p.m. (Exh. 16, pp. 28-29.) Dr. Greenberg noted that the patient's circumstances and risk factors had changed substantially between the time patient P.W. signed the form and the time respondent decided to perform a vacuum assisted vaginal operative delivery and actually began the procedure, after 3:00 p.m.

53. Respondent argued that proper informed consent for the vacuum-assisted operative procedure was established with the patient's signature on a standard informed consent form that included reference to use of a vacuum in the delivery. Dr. Greenberg credibly testified that proper informed consent for the vacuum-assisted delivery in this case required a conversation with patient P.W. (and her husband, if present) at a time close enough to the procedure to enable a discussion of the risks and benefits of the procedure at that specific time, and the alternatives then available, in light of the circumstances then present. That was not done in this instance which, Dr. Greenberg opined, constituted gross negligence.

54. Dr. Greenberg also credibly opined that respondent was negligent in his care and treatment of patient P.W. in that he did not assess glucose control in the face of gestational diabetes by failing to: (a) perform glucose surveillance during the pregnancy; (b) estimate fetal weight during the antenatal course by ultrasound or clinical examination; or (c) estimate fetal weight at the time of hospital admission.

55. Dr. Greenberg also credibly opined that respondent was negligent in his care and treatment of patient P.W. when he failed to appropriately assess and treat the cause of the

patient's postpartum hemorrhage (PPH). The ACOG Bulletin regarding PPH (Exh. 35) highlights the significance and seriousness with which PPH must be taken, noting at the outset that it is the "single most significant cause of maternal death worldwide. More than half of all maternal deaths occur within 24 hours of delivery, most commonly from excessive bleeding." (Exh. 35, p. 1.) At the time the ACOG Bulletin was published in October of 2006, an estimated 140,000 women died from PPH each year. (*Id.*) Although there are risk factors for PPH (several of which patient P.W.), PPH can occur without warning and must be an emergency that obstetric practitioners are prepared to manage. Respondent failed to properly consider etiologies other than uterine atony as the cause of P.W.'s PPH. Dr. Greenberg opined that respondent's failure to follow the ACOG Guidelines in addressing and treating P.W.'s PPH represents a simple departure from the standard of care.

56. Dr. Greenberg opined that respondent committed a simple departure from the standard of care for his failure to assess glucose control in the face of patient P.W.'s gestational diabetes. Her opinion is based upon the standard of care set forth in ACOG Practice Bulletin 37, Gestational Diabetes Mellitus. (Exh. 13, p. 4; Exh. 37.) As articulated in ACOG Practice Bulletin 137 and in Dr. Greenberg's expert opinion, treatment of gestational diabetes reduces the risk of complications, including shoulder dystocia. Monitoring patients' glucose levels throughout the course of the pregnancy is important to reduce the risks produced by gestational diabetes, yet Dr. Greenberg did not locate in respondent's records specific documentation of glucose levels. Babies born to women with gestational diabetes are often larger and often have a growth pattern where they have more of a truncal body mass that puts them at increased risk for shoulder distortion, and the attendant risks of nerve injury, lack of oxygen to the baby, and maternal trauma associated with relieving the shoulder dystocia.

Patient L.N.

57. Dr. Greenberg credibly opined that respondent was grossly negligent, engaged in repeated negligent acts, and demonstrated incompetence in his care and treatment of patient L.N.

58. As with patient P.W., respondent failed to appropriately assess and manage the underlying cause of patient L.N.'s PPH. Dr. Greenberg opined that this constituted a simple departure from the standard of care.

59. Management of PPH first requires an understanding of the etiology, then an evaluation of the patient consistent with that understanding, and then taking the appropriate action based on the evaluation. Dr. Greenberg credibly opined that in a case of PPH, a physician must always consider uterine atony, surgical bleeding and coagulopathy as possible causes. Respondent treated patient L.N. for uterine atony only. He used uterotonic agents and a Bakri balloon, but he failed to consider surgical bleeding or coagulopathy as possible alternative causes of patient L.N.'s post-cesarean section hemorrhage. Because respondent did not consider coagulopathy as a cause of patient L.N.'s PPH, he did not initiate

appropriate replacement, consultation, or activation of a hemorrhage protocol for patient L.N.

60. Moreover, respondent did not explicitly document atony in patient L.N.'s medical record. Respondent noted in the medical record that the gush of blood postpartum was estimated at 1,000 cc, but he did not reference any additional blood loss. Respondent later stated that he expected patient L.N.'s hemoglobin to increase above 10. Respondent's discharge summary noted the cause of DIC was amniotic fluid embolism and PPH, although there was never any suspicion of amniotic fluid embolism prior to, during, or after delivery. Because patient L.N. was not bleeding vaginally, respondent believed her bleeding was controlled, and he did not consider intraperitoneal bleeding.[15] Dr. Greenberg credibly opined that when hypotension occurs in the face of transfusion, or the rise in the H/H is sub-adequate in the post-operative patient, a physician must consider intraperitoneal bleeding and the underestimation of blood loss.

61. The first Bakri balloon placed by respondent had fallen out approximately one hour after it was inserted. Although patient L.N. appeared to be stable at the time respondent left the hospital at 12:52 a.m, the second Bakri balloon had been in place only six minutes at the time respondent left the hospital. Dr. Greenberg credibly opined that at that time, "either there needed to be observation or a clear care plan as to who was doing that observation." Respondent's failure to directly communicate with other physicians or nursing staff who were assuming the transfer of L.N.'s care constituted a simple departure from the standard of care, according to Dr. Greenberg.

62a. When respondent left the hospital, he failed to take the necessary steps to ensure there was appropriate follow-up of vital signs and laboratory tests to guide further care of patient L.N. Respondent did not communicate with, consult or collaborate with other health care providers in regard to his patient. Due to L.N.'s critical and complicated medical status, prior to leaving the hospital, the standard of care required that respondent transfer care by discussing the details of her case and plan of care, and delineate responsibility.

62b. Respondent never spoke with Dr. Hakim, who he believed would assume the care of L.N. There was obvious lack of clarity as to who had continuing responsibility for the patient once respondent went home. The record did not establish that other providers were given sufficient information by respondent as to L.N.'s case history and the plan for continuing care, including receipt of blood products, obtaining labs, circumstances in which a nurse should take action and specific action that should be taken in different circumstances.

63. The communication between Dr. Kao and Dr. Hakim was insufficient. Respondent failed to communicate substantively with other care providers who he contended would be responsible for the patient's care. Respondent did not know the ICU nursing staff and did not commonly admit patients to the ICU. Under these circumstances, clear and careful communication was essential.

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[15] Presence of blood in the peritoneal cavity.

64a. Dr. Greenberg credibly opined that in failing to properly manage an unstable patient, respondent committed an extreme departure from the standard of care and was grossly negligent in the care and treatment of patient L.N. She bases her opinion on ACOG Practice Bulletin Number 76, PPH. There was a lack of appropriate follow-up of vital signs and labs to dictate further care. Respondent ordered uterine artery embolization, which is contraindicated in a patient with unstable vital signs, rather than proceeding with surgical assessment and treatment of L.N.'s bleeding.

64b. Upon respondent's return to the hospital, both Dr. Afrasiabi and Dr. Hakim, were in favor of L.N. returning to surgery to receive a hysterectomy. However, respondent chose to perform a uterine artery embolization instead. Because L.N. was unstable, had coded and had ongoing bleeding, Dr. Greenberg credibly opined that L.N. was not a candidate for uterine artery embolization, based upon ACOG Guidelines. Rather, the appropriate care at that point would have been a hysterectomy.

65. Dr. Greenberg credibly opined that respondent was grossly negligent and committed an extreme departure from the standard of care when, despite a maternal death, he failed to assess potential changes in his practice procedures to improve patient safety. She suggested several changes to his practice that respondent should have implemented after this incident, but did not. These include improving his communication with nurses and consultants; ensuring that ICU nurses know when he wants to be called; confirming when care of the patient is being transferred to another physician; and ensuring that he continues to responsibly handle all OB-related issues for his patients, even after transfer to the ICU.

66. Subsequent to this incident, respondent has failed to take steps to ensure prompt consultation with subspecialists and experts in critical situations that are beyond the scope of his usual practice; failed to shift his practice in any other way that might help improve patient safety such as staying in the hospital to facilitate ongoing assessment of a patient who has suffered a major complication; assessing blood loss; activating transfusion protocols for factor replacement; or ensuring that when there is ongoing bleeding in an unstable patient, a hysterectomy is performed without delay.

67. Dr. Greenberg credibly opined that:

A. Respondent was grossly negligent in his care and treatment of patient L.N. in that he inappropriately assessed and managed her postpartum hemorrhage.

B. Respondent was negligent in the care and treatment of patient L.N. in that he failed to properly manage an unstable patient.

C. Respondent was negligent in his care and treatment of patient L.N. in that he assumed he had transferred care of patient L.N. even though he had had no direct communication with other physicians or nursing staff.

D. Respondent was negligent when, despite a maternal death, he failed to assess potential changes in his practice procedures to improve patient safety.

E. Respondent demonstrated incompetence in that he failed to consider the possibility of consumptive coagulopathy in patient L.N. Respondent also failed to assess coagulopathy, to obtain appropriate replacement of coagulation factors and/or platelets or to activate a hemorrhage protocol. Respondent documented in his dictated discharge summary notes that the cause of DIC was amniotic embolism and PPH, though there was no suspicion of amniotic fluid embolism before, during or after delivery.

F. Respondent demonstrated incompetence in that he failed to consider the possibility of intraperitoneal bleeding in patient L.N. after delivery when she was not bleeding vaginally. Respondent failed to consider that in the post-operative patient, when hypotension occurs in the face of transfusion or the rise in the H/H is subadequate, intraperitoneal bleeding should be considered and underestimation of blood loss should also be considered.

Patient X.H.

68. Dr. Greenberg credibly opined that respondent engaged in repeated negligent acts in his care and treatment of patient X.H.

69. Respondent was negligent in performing group B Strep screening at approximately 24 weeks gestation rather than between 35 to 37 weeks gestation. This represents a simple departure from the standard of care. Dr. Greenberg based this assertion on ACOG's Committee Opinion on Prevention of Early Onset Group B, Number 485 (Exh. 38.)

70. Respondent was negligent when he failed to estimate fetal weight despite lagging fundal height at 39 weeks gestation. Dr. Greenberg indicated there was no clinical estimated fetal weight noted in the chart, nor did respondent order an ultrasound. This represents a simple departure from the standard of care. An ultrasound at 26 weeks gestation had shown a fetus with appropriate growth for the gestational age. However, at a prenatal appointment at 39 weeks gestation, respondent recorded a fundal height of 35 cm. The rate of growth had slowed and the fundal height relative to the gestational age, according to guidelines by ACOG Practice Bulletin, Fetal Growth Restriction, Number 134, placed the fundal height into a category where respondent needed to obtain the weight of the baby. One simple method of doing so would have been to order an ultrasound. Dr. Greenberg opined that respondent's failure to order an ultrasound or take other steps to obtain the weight of the baby violated the standard of care and constituted negligence.

Patient K.B.

71. Dr. Greenberg credibly opined that respondent engaged in repeated negligent acts, in his care and treatment of patient K.B.

72. Respondent was negligent in the care and treatment of patient K.B. when he performed group B Strep screening at approximately seven weeks gestation rather than

between 35 to 37 weeks gestation. Dr. Greenberg opined that this was a simple departure from the standard of care.

73. Respondent was negligent in the care and treatment of patient K.B when he failed to assess for fetal growth restriction. Fundal height was lagging in weeks 29, 36, 37 and 38. Dr. Greenberg testified that the records show recorded fundal heights, but no another assessment of fetal weight, despite the lagging fundal heights. The medical chart for patient K.B. does not contain an express assessment for fetal growth restriction by respondent. Dr. Greenberg credibly opined that this represents a departure from the standard of care. ACOG's Practice Bulletin Number 134 on Fetal Growth Restrictions states that if the number of centimeters of fundal height varies by 3 or more from the number of weeks of gestation, fetal growth restriction should be suspected and an ultrasound should be performed. That guidance was not followed by respondent. It constituted a simple departure from the standard of care.

Respondent's Expert Denis Tarakjian, M.D.

74. Respondent's expert Dr. Denis Tarakjian, M.D. testified as an expert witness on behalf of respondent. He graduated from St. George's College of Medicine in Grenada in 1982 and completed an internship and residency at Temple University in 1987. He is Board-certified as an OB/GYN and has 35 years of experience in that field. He maintains a full-time practice as an OB/GYN. From 1987 to the present, he has been employed at Sharp Reese Stealy Medical Group and has cared for close to one million OB/GYN patients. Dr. Tarakjian reviewed medical records, investigative reports, declarations and transcripts and opined that respondent's care and treatment of his patients comported with the standard of care with respect to patients L.N., P.W., X.H. and K.B.

Patient L.N.

75. Dr. Tarakjian opined that respondent was not negligent in the care and treatment of L.N. in that when there were any issues, respondent "was there managing them," and the patient was stable when respondent left the hospital at 12:52 a.m. on March 10, 2014, and transferred over her care.

76. Dr. Tarakjian testified that everything respondent did in his care and treatment of L.N. comported with ACOG Guidelines, and was well within the standard of care. He noted the medications respondent gave the patient in an attempt to stop the uterine bleeding were in keeping with ACOG Guidelines, as was his use of a Bakri balloon. Dr. Tarakjian opined that respondent appropriately gave the patient PRBCs and FFP within the ACOG Guidelines. Dr. Tarakjian noted that there was no blood visualized in the collection device at the time respondent replaced the balloon after it dislodged, in accordance with nurse Nguyen's civil testimony that L.N.'s pad was dry and free of blood.

77. Dr. Tarakjian based his determination that patient L.N. was stable when respondent left the hospital upon the declaration of Dr. Kao (Exhibit E); the civil trial testimony of nurse Nguyen (Exh. A, pp. 542-547); the hearing testimony of Dr. Wang; and

respondent's testimony at hearing. Dr. Tarakjian noted that when respondent left the hospital, L.N. had exhibited a slightly elevated heart rate, a normal oxygen saturation rate, and stable blood pressures for a lengthy period of time. (Exh. 24 A, p. 61).

78. Dr. Tarakjian opined that because patient L.N. was no longer stable when respondent returned to the hospital at approximately 3:30 a.m. on March 10, 2014, he reasonably chose not to take L.N. back to surgery after she had coded, based upon respondent's assessment of risk to the patient. Dr. Tarakjian also stated that respondent could not have taken the patient to the OR because he would have been unlikely to find an anesthesiologist willing to put L.N. under general anesthesia at that point.

79. Dr. Tarakjian understood that at the time Dr. Liu left the hospital, patient L.N. and her mother were opposed to having him perform a hysterectomy because L.N. wished to have an additional child in the future. He testified that given the patient's stable condition at that time, respondent properly acted upon his patient's wishes.

80. Dr. Tarakjian opined that L.N.'s death was not attributable to a departure from the standard of care by respondent. Dr. Tarakjian noted a DIC test respondent had ordered before he left the hospital had been inexplicably canceled and, prior to 3 a.m., no one from the hospital called respondent to report that the patient's condition had been deteriorating.

81. Dr. Tarakjian opined that there was nothing respondent should have done differently with respect to his care and treatment of patient L.N.

82. Dr. Tarakjian's testimony focused on whether or not patient L.N. was stable at the time respondent left the hospital and immediately upon respondent's return. He failed to address the issues raised by Dr. Greenberg regarding respondent's failure to properly manage the patient over time. Respondent argues that he could not take the patient to surgery upon his return because she was not stable, and therefore, he was not negligent. Respondent misconstrues the allegation in this matter. Dr. Greenberg established that respondent should never have left the patient, given her condition. Had he remained with the patient, he could have stabilized the patient in order to address her issues surgically.

83. Regarding L.N., the Accusation alleges respondent was grossly negligent in that he failed to properly manage L.N., an unstable patient. Dr. Tarakjian primarily focused on the issue of whether or not respondent had caused the patient's death. However, that was not alleged in the Accusation. Respondent's failure to manage patient L.N. was alleged and established by clear and convincing evidence.

84. Respondent did not appropriately assess and manage patient's L.N.'s postpartum hemorrhage. Dr. Tarakjian testified as to whether the patient was stable at 12:52 a.m. However, Dr. Greenberg established that in the course of addressing the patient's blood loss, respondent failed to pursue all of the avenues dictated by ACOG protocol for this presentation. (Exhibit 35.) Respondent only attempted to address the uterine atony. He failed to assess for coagulopathy, which was causing the PPH. This represents, as alleged in the Accusation, a failure to properly manage the patient.

Patient P.W.

85. Dr. Tarakjian reviewed the consent forms signed by patient P.W. He contended that proper informed consent for the vacuum-assisted operative procedure was established with the patient's signature on a standard informed consent form that included reference to use of a vacuum in the delivery. Dr. Tarakjian noted that the standard hospital informed consent forms identified the procedures to be performed, were signed by patient P.W., witnessed by a member of the hospital staff, and signed by respondent. He deemed that to constitute "adequate" informed consent.

86. Dr. Tarakjian opined that respondent had not committed gross negligence by failing to estimate, or document that he had estimated, fetal weight. He noted that respondent had documented both the fundal height and the baby's length. Therefore, in light of respondent's more than forty years' experience delivering babies, Dr. Tarakjian opined that respondent would have been able to capably estimate the fetal weight. Dr. Tarakjian relied on the fact that, in this instance, the baby's size was clinically appropriate for gestational age and respondent had an indication that the baby was in vertex. Dr. Tarakjian stated that if a baby is average for gestational age, physicians do not usually document an estimated fetal weight. They do so only if the baby is disproportionately large or disproportionately small.

87. Dr. Tarakjian opined that respondent had not committed gross negligence by failing to determine, or document that he had determined, the position of the fetal head. Dr. Tarakjian noted that in performing a vacuum extraction, respondent had to have made an evaluation of the baby's position in order to know where to place the vacuum. Dr. Tarakjian stated that documenting the position of the fetal head "would seem frivolous because you're really trying to get the baby out and not create a paper trail, per se."

88. Dr. Tarakjian disagreed with the assertions that respondent was negligent when he failed to assess glucose control, in the case of gestational diabetes, by failing to perform glucose surveillance during P.W.'s pregnancy. Dr. Tarakjian noted that in the patient's chart (Exhibit 17, page 7), respondent wrote the word "sugar" after the word "urine" for each of her eight visits. Thus, he concluded that respondent had tested P.W.'s urine for sugar at each visit.

Patient K.B.

89. Dr. Tarakjian disagreed with the assertion that respondent was negligent in failing to perform the group B strep test at 35 to 37 weeks gestation for patient K.B. He noted that respondent did perform the strep test at seven weeks gestation. Since patient K.B was given prophylactic antibiotics at the time of her admission to the hospital, Dr. Tarakjian could not conclude that performing the test on patient K.B. at seven weeks was in error; he simply deemed it to have been "an extra test." He agreed that while the test should optimally be given at 35 to 37 weeks, giving the antibiotics upon admission "would address anything that might have been missed."

90. Dr. Tarakjian disagreed with the assertion that respondent was negligent in failing to assess patient K.B. for fetal growth restriction. He opined that, in light of respondent's years of experience as an OB/GYN, respondent was able to competently assess fetal size because respondent had been measuring fundal heights throughout patient K.B.'s pregnancy. Moreover, since respondent had performed multiple ultrasounds on patient K.B., Dr. Tarakjian opined that respondent had properly assessed fetal growth restriction.

Patient X.H.

91. Dr. Tarakjian disagreed with the assertion that respondent was negligent in failing to perform a group B strep test for patient X.H. at 35 to 37 weeks gestation. He noted that respondent did perform the strep test at 24 weeks gestation, although optimally the test should be given at 35 to 37 weeks. As with patient K.B., Dr. Tarakjian opined that since patient X.H. was given prophylactic antibiotics at the time of her admission to the hospital, he did not deem respondent to have been negligent by committing a departure from the standard of care. Respondent's argument that prophylactic administration upon hospital admission cured the defect is not persuasive in light of Dr. Greenberg's testimony that had the testing been done in accordance with the standard of care, mother and child could have been spared unnecessary antibiotic treatment, which is strongly discouraged.

92. Nor did Dr. Tarakjian believe that respondent was negligent when he failed to estimate fetal weight despite lagging fundal height at 39 weeks gestation. Based upon ACOG practice bulletin (Q 6 and 7), Dr. Tarakjian opined that measuring the fundal height is only applicable up to 38 weeks. Therefore, he concluded that measuring the fundal height at 39 weeks is of no value.

Respondent's Expert Corey Marco, J.D., M.D.

93. Dr. Marco has 51 years of experience as a physician. He is Board-certified as a family practice physician. He graduated summa cum laude from University of California Los Angeles Medical School in 1967 and received his J.D. degree from Stanford Law School in 1975. He served as the Chief of Staff at El Cajon Valley Hospital's ER for two years and is now retired.

94. Dr. Marco opined that when a physician admits a patient to the ICU, typically the patient will be managed by an intensivist with expertise in critical care, rather than by the admitting physician. He has never had privileges at Garden Grove Hospital and has not seen its rules or by-laws. Dr. Marco had not reviewed the entire record in this case, and stated that his role was simply to testify about the transfer of care when L.N. entered the ICU.

95. Dr. Marco often spoke with the intensivist when one of his patients was transferred to the ICU, but did not do so in every case and opined that such discussions are not always necessary. On "many occasions," Dr. Marco spoke with the ICU nurse if the nurse had questions or if he wanted to check on the patient's status.

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Respondent's Evidence

96. Respondent attended China Medical College in Taiwan. He served as an army physician in Taiwan after graduating medical school in 1970. Respondent immigrated to the United States in 1973, and came to California in 1981. He asserted at hearing that he practices medicine because he loves his patients. He still has an active OB/GYN practice, seeing approximately 35 to 40 patients each week. Respondent hopes to practice medicine for another five to 10 years.

97. Respondent contended that all of his actions involving the patients identified in the Accusation comported with ACOG Guidelines. Since the events described in the Accusation, he has taken additional continuing medical education (CME) courses beyond those required for continued licensure, and he completed a medical record-keeping course given by the Physician Assessment and Clinical Education Program (PACE) at the University of California, San Diego.

98. As for patient L.N., respondent stabilized the patient, making sure her blood pressure was normal and her bleeding had stopped. Respondent spoke to L.N.'s mother, who told him that her daughter did not want a hysterectomy and had experienced PPH after her previous C-section. The mother explained that her daughter now had two sons, but would like to have a girl in the future.

99. Respondent asserted that patient L.N.'s vital signs were stable when he left to go home and he justifiably relied on many other medical professionals who assured him of the patient's stability, including Dr. Kao, Dr. Wang and Nurse Nguyen. Respondent explained that L.N would ordinarily have been sent to the recovery room after her surgery, but because no one covers the recovery room at night, L.N. was transferred to the ICU. Dr. Kao called Dr. Hakim to let him know that L.N. was coming to the ICU.

100. Respondent acknowledged that he remains responsible for all OB-related issues for his patients, even when those patients have been transferred to the ICU. Respondent ordered additional tests to confirm patient L.N. remained stable, but the tests were inexplicably canceled by the ICU nursing staff.

101. When L.N. became hypotensive and began bleeding while in the ICU, the ICU nurse did not contact respondent, the internist or the intensivist. It was not until patient L.N. coded shortly after 3:00 a.m. on March 10, 2015, that respondent was called by the ICU nurse. Respondent immediately returned to the hospital, arriving within 14 minutes. Dr. Hakim still was not at the hospital. At the time of respondent's return, an ER physician was intubating patients L.N. Respondent testified that the ER doctor and critical care doctor would direct patient L.N.'s care at that point.

102. Two weeks after patient L.N.'s death, Garden Grove Hospital placed respondent "on a proctoring program" and conducted an investigation. The proctoring monitoring reports were positive (Exhibit P.) At some point, Garden Grove Hospital

suspended respondent's privileges. On October 15, 2015, he took "a leave of absence" and has not returned to Garden Grove Hospital.

103. Respondent argues that he could not take patient L.N. to surgery upon his return because she was not stable, and therefore, he was not negligent. Respondent's focus was on establishing that he did not negligently cause the patient's death by leaving the hospital at 12:52 a.m. or by failing to take the patient to the OR when he returned to the hospital at 3:34 a.m. Respondent misconstrues the allegations in this matter. The focus is not on causation of the tragic death of this patient. Rather, complainant's focus is whether respondent's care and treatment of patient L.N. over time conformed to the standard of care.

104. With respect to patients K.B. and X.H., respondent does not dispute that he did not perform group B strep screening at 35 to 37 weeks' gestation in compliance with the standard of care and ACOG Guidelines. He asserted that providing prophylactic antibiotics at the time of the patients' admission cured the departure. Since these events, respondent has been performing the Group B Strep test at 35 to 37 weeks.

105. In regard to patient P.W., respondent did not contend that he recorded an estimate of fetal weight at the hospital. Rather, he suggested that it is not necessary because as an experienced OB/GYN who has delivered over 10,000 babies, he is able to extrapolate fetal weight based upon fundal height information in prenatal records. Similarly, respondent did not assert that he documented the position of the fetal head. Instead, he implies that it is obvious that he knew the baby's position because he used a vacuum. In addition, respondent asserts that documenting the baby's position is not necessary because documentation of using a vacuum is sufficient to convey where the fetal head position was. He is emphatic about his position, insisting that the Board's position is "wrong."

Character References

106. Four character witnesses testified at the hearing as to respondent's skill and quality as a physician and surgeon. They described respondent as a highly respected member of the medical community who provides quality patient care, and whose knowledge and skills are sought after by a younger generation of physicians. Respondent also submitted declarations from Dr. Kao and Dr. Hong-An Jan, both of which were admitted as administrative hearsay. (Exhs. E and K.)

107. Peter F. Wang, M.D., testified on respondent's behalf. Dr. Wang, the former Chief of Staff of Garden Grove Hospital, assisted respondent during L.N.'s surgery. He admitted that he is aware of only portions of the Accusation. Dr. Wang has been licensed in California since 1980 and is a Board-certified OB/GYN. Dr. Wang has been a friend of respondent for 58 years and has "cross-covered" respondent's patients for nearly 40 years. He has never received any complaints from patients regarding respondent. Dr. Wang described respondent as "very experienced and a good surgeon" who "is an asset to the Orange County medical community." He stated that he has had "no reason to question [respondent's] judgment. Dr. Wang was the surgeon who assisted respondent with patient L.N.'s "uneventful" C-section. Dr. Wang stated that to the best of his recollection, when he

left the hospital at 11 p.m. that night, patient L.N.'s bleeding had stopped, the patient's vital signs showed she was stable and respondent handled the patient's bleeding in accordance with "hospital and ACOG hemorrhage protocol." Dr. Wang observed respondent place the Bakri balloon and opined that no hysterectomy was needed at that time.

108. Thanh Mai Trinh, M.D., testified on respondent's behalf. She has known him for 18 years and has often assisted him in surgery. Dr. Trinh described respondent as "very professional," always on-time and honest, with excellent skills. She seeks respondent's help with "difficult cases." Dr. Trinh testified that respondent is the "go-to doctor" for other physicians and is does not care whether a patient has insurance coverage. Respondent routinely provides his personal cell phone number to his patients. Dr. Trinh had not seen the Accusation.

109. Annmarie Nguyen, M.D., testified on respondent's behalf. She has been a Board-certified OB/GYN since 1996 and has known respondent since 1997. Dr. Nguyen was not familiar with the allegations of the Accusation "in detail." She has observed respondent in surgery "many times" and has never heard any patient complaints about respondent. Dr. Nguyen testified that respondent is "well-loved and respected," has an excellent bedside manner, and always takes the time to talk with patients before surgery. She has assisted respondent in surgery and he often assists her with C-sections, hysterectomies and complicated cases. Respondent is her "first call" because he is "very competent," "extremely helpful" and "always has a way of solving problems."

110. Hyung O. Kim, M.D., testified on respondent's behalf. He has been a Board-certified OB/GYN since 1983. Dr. Kim has known respondent for 35 or 36 years and has "cross-covered" many cases with him. Dr. Kim has assisted respondent in surgery one hundred times, and respondent covered Dr. Kim's practice every Wednesday for over 30 years. Dr. Kim has never heard any patient complaints about respondent. Respondent has excellent surgical skills and assists Dr. Kim with "tough cases." Dr. Kim has not seen the Accusation and did not have privileges at Garden Grove Hospital when the events of this matter transpired.

Analysis

111. The standard of care for a given profession is a question of fact and in most circumstances must be proven through expert witnesses. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215; see 6 *Witkin, Summary of California Law* (9th Ed.), Torts, sections 749, 750, and 774.) However, in some cases the standard may be defined by a statute or regulation. California law defines "standard of care" as the use of that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. (*Flowers, supra,* 8 Cal. 4th at pp. 997-998.)

112. Dr. Greenberg, complainant's expert witness, provided credible and persuasive testimony solidly based upon specific references to the pertinent ACOG Guidelines. She did

not advocate for one side or the other. Rather, her answers were direct, honest, and thoughtful, without regard to whether or not they helped either party. On the other hand, respondent's expert, Dr. Tarakjian, justified each of respondent's actions in the care and treatment of these patients and glossed over respondent's failure to comply with ACOG Guidelines in providing care and treatment to these women. The testimony of respondent's expert, Dr. Marco, was limited solely to the issue of patient L.N.'s transfer to the ICU. Since he had no experience at Garden Grove Hospital and was not familiar with its procedures, his testimony was accorded little weight.

LEGAL CONCLUSIONS

1. Cause exists to discipline respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), for gross negligence in relation to his care and treatment of patients P.W. and L.N., as set forth in Factual Findings 4-39; 45-67; and 111-112.

2. Cause exists to discipline respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), for repeated negligent acts in relation to his care and treatment of patients P.W., L.N., X.H. and K.B., as set forth in Factual Findings 4-73 and 111-112.

3. Cause exists to discipline respondent's certificate, pursuant to Business and Professions Code section 2234, subdivision (d), in that he demonstrated incompetence in relation to his care and treatment patient L.N., as set forth in Factual Findings 22-39; 57-67; and 111-112.

The Applicable Law

4. The standard of proof which must be met to establish the charging allegations herein is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests with complainant to offer proof that is clear, explicit and unequivocal-- so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

5. The purpose of the Medical Practice Act[16] is to assure the high quality of medical practice; in other words, to keep unqualified and undesirable persons and those guilty of unprofessional conduct out of the medical profession. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App. 3d 564, 574.) The imposition of license discipline does not depend on whether patients were injured by unprofessional medical practices. (See, *Bryce v. Board of Medical Quality Assurance* (1986) 184

[16] Business and Professions Code sections 2000 through 2521.

Cal.App.3d. 1471; *Fahmy v. Medical Board of California* (1995) 38 Cal.App.4th 810, 817.) Our courts have long held that the purpose of physician discipline by the Board is not penal but to "protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity." (*Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, 331.

6. "The law demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he exercise ordinary care in applying such learning and skill to the treatment of his patient. (Citations.) The same degree of responsibility is imposed in the making of a diagnosis as in the prescribing and administering of treatment. (Citations.) Ordinarily, a doctor's failure to possess or exercise the requisite learning or skill can be established only by the testimony of experts. (Citations.) Where, however, negligence on the part of a doctor is demonstrated by facts which can be evaluated by resort to common knowledge, expert testimony is not required since scientific enlightenment is not essential for the determination of an obvious fact. (Citations.)" (*Lawless v. Calaway* (1944) 24 Cal.2d 81, 86.)

7. Business and Professions Code section 2234 states that the Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes (b) gross negligence; (c) repeated negligent acts (two or more negligent acts); and (d) incompetence.

8. Gross negligence has been defined as an extreme departure from the ordinary standard of care or the "want of even scant care." (*Gore v. Board of Medical Quality Assurance* (1970) 110 Cal.App.3d 184, 195-198.)

9. A "negligent act" as used in [Business and Professions Code section 2234] is synonymous with the phrase, "simple departure from the standard of care." (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462.)

10. Incompetence has been defined as a "general lack of present ability to perform a given duty as distinguished from inability to perform such duty as a result of mere neglect or omission." (*Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 837-838.) "[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty." (*Id.* at p. 838.)

11. California Code of Regulations, title 16, section 1360, states that for the purposes of denial, suspension or revocation of a license, an act shall be considered to be substantially related to the qualifications, functions or duties of a licensee if to a substantial degree it evidences present or potential unfitness to perform the functions authorized by the license in a manner consistent with the public health, safety or welfare. Such acts include violating any provision of the Medical Practice Act.

Appropriate Level of Discipline

12. Complainant seeks revocation of respondent's certificate. While revocation falls into the range of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders*, particularly when gross negligence is involved, such discipline is not warranted in this matter. Respondent has enjoyed a long period of practice with no prior record of discipline, and he is well-regarded in the medical community.

13. The minimum period of discipline set forth in the Board's *Manual of Disciplinary Guidelines and Model Disciplinary Orders* is five years' probation for the types of violations established in this matter. The purpose of a disciplinary action such as this one is to protect the public, and not to punish the licensee. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164; *Small v. Smith* (1971) 16 Cal.App.3d 450, 457.) In this case, the public would be adequately protected by the imposition of a five-year period of probation, with specific terms and conditions.

ORDER

Certificate No. A 36134 issued to respondent Long-Dei Lui, M.D., is revoked. However, the revocation is stayed and respondent is placed on probation for five years, upon the following terms and conditions:

1. Notification

Within seven days of the effective date of this Decision, Respondent shall provide a true and correct copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

2. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

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3. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

4. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

5. General Probation Requirements

Compliance with Probation Unit:

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes:

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice:

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal:

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California:

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

6. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

7. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

8. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

9. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall, within 15 calendar days, deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

10. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

Date: September 4, 2018

DocuSigned by:
Laurie R. Pearlman
[illegible]
LAURIE R. PEARLMAN
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Long-Dei Liu, M.D.** **12555 Garden Grove Blvd., No. 402** **Garden Grove, CA 92843** **Physician's and Surgeon's Certificate No. A 36134,** Respondent.	Case No. 800-2014-009126 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about December 8, 1980, the Board issued Physician's and Surgeon's Certificate Number A 36134 to Long-Dei Liu, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2018, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following

laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2229, subdivision (a), of the Code states:

"Protection of the public shall be the highest priority for the Division of Medical Quality,[1] the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority."

5. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

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[1] Pursuant to Business and Professions Code section 2002, the "Division of Medical Quality" or "Division" shall be deemed to refer to the Medical Board of California.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent Long-Dei Liu, M.D. is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in his care and treatment of three patients. The circumstances are as follows:

Patient P.W.[2]

9. In or around November of 2014, patient P.W., a 40 year-old Gravida 3 Para 1[3] female at 31 weeks gestation who began prenatal care in China, transferred care to Respondent. Patient P.W. had diet-controlled gestational diabetes. Respondent did no glucose surveillance during her

[2] Initials are used to protect the privacy of individuals.

[3] Gravidity refers to the number of times a female has been pregnant, including the current pregnancy. Para is short for parity and it refers to the number of times the pregnancies have been carried to a viable gestational age.

pregnancy. He did not estimate fetal weight during the antenatal course by either ultrasound or clinical examination.

10. On or about January 21, 2015, at 39 4/7 weeks gestation and in labor, patient P.W. was admitted to Coastal Communities Hospital. At 1:43 p.m., she was 4 cm dilated, with spontaneous rupture of the membranes and clear amniotic fluid. Late decelerations were noted.

11. At 2:00 p.m., Respondent was called to come evaluate the patient. At 2:05 p.m., an epidural was placed. The fetal monitor strip was noted to be category II with late decelerations that improved with intravenous (IV) fluids, oxygen and maternal repositioning.

12. At 2:30 p.m., late decelerations recurred. Respondent was notified.

13. At 2:45 p.m., Respondent arrived at the bedside. At that time, contractions were noted every 1-1.5 minutes consistent with hyper-stimulation and the nurse requested administration of terbutaline, which Respondent denied. Respondent remained at the bedside and placed an internal fetal monitor and intrauterine pressure catheter. Respondent did not estimate fetal weight by either ultrasound or clinical examination.

14. At 3:07 p.m., there were prolonged decelerations with absent variability with the fetal heartrate (FHR) down to 67- 60 beats per minute (bpm), and the nurse requested that Respondent perform a stat cesarean section. Respondent instead opted for a vacuum-assisted vaginal delivery because the patient's cervix was rapidly dilating and she was then an anterior rim.

15. At 3:20 p.m. a vacuum-assisted vaginal delivery was performed with a kiwi vacuum over a median episiotomy, the head delivered and a shoulder dystocia ensued. The fetal heart rate tracing had been noted to be category III and then was not recordable during the 10 minute interval between delivery of the baby's head and delivery of the body.

16. At 3:30 p.m., the infant was delivered with Apgars of 0/0/2/7.[4] The placenta was removed manually, and the episiotomy repaired. Prophylactic antibiotics were given. The estimated blood loss from the delivery is not noted in the medical records.

[4] Apgar is a quick test to evaluate the health of a newborn on a scale of 1 to 10. It includes evaluation of the baby's breathing effort, heart rate, muscle tone, reflexes and skin color and is performed at various points after birth typically including 1 minute and 5 minutes after birth.

17. At 4:53 p.m., patient P.W.'s blood pressure (BP) was 81/42 and her heartrate was 157 bpm. At 4:58 p.m., patient P.W.'s blood pressure was 85/66 and her heartrate was 125 bpm. At 5:15 p.m., patient P.W.'s blood pressure was 85/66 and her heartrate was 125 bpm.

18. At 5:40 p.m., heavy bleeding was noted, the uterus was noted to be firm, and there was maternal tachycardia to 120. A large IV was reinserted and Respondent was called.

19. At 6:00 p.m. there was ongoing bleeding. Patient P.W.'s uterus was firm at the umbilicus. Respondent did not perform evaluation for etiologies of blood loss other than uterine atony. Patient P.W.'s blood pressure was 68/52 and her heartrate was 119 bpm. Patient P.W.'s H/H/platelets[5] was 8.5/26.2/81, whereas prior to delivery, they had been 11.8/36.9/131. Respondent placed a Bakri balloon and vaginal packing and ordered a transfusion of 2 units of packed red blood cells (PRBC's). Petocin[6] and Methergine[7] were administered.

20. At 6:45 p.m., patient P.W.'s blood pressure was 94/55 and her heartrate was 106 bpm. The first unit of PRBC was transfused. Patient P.W. was still bleeding. Although Petocin and Methergine had been administered, at 6:45 p.m., she was still bleeding. She was consented for surgical vaginal exploration and possible abdominal hysterectomy. A complete blood panel (CBC) and disseminated intravascular coagulation (DIC)[8] panel were ordered, and 4 units of packed red blood cells were ordered, one of which was transfused before surgery. The labs returned with an H/H/platelets of 10.4/32.4/80; PT 28.2, INR 2.6, PTI 69.7, and fibrinogen <90, consistent with a coagulopathy.

21. At 7:18 p.m., patient P.W.'s blood pressure was 95/60 and her heartrate was 118 bpm. The second unit of PRBC's was transfused.

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[5] H/H refers to hemoglobin and hematocrit.

[6] Petocin is the brand name of the hormone oxytocin, which stimulates contractions in the uterus.

[7] Methergine, brand name for methylergonovine maleate, belongs to the ergot alkaloids class of medicine. It works by acting directly on the smooth muscles of the uterus to prevent or control bleeding after giving birth.

[8] Disseminated intravascular coagulation is a serious disorder in which the proteins that control blood clotting become overactive.

22. At 7:55, patient P.W.'s blood pressure was 117/66 and her heartrate was 106 bpm. The first unit of fresh frozen plazma (FFP) was transfused.

23. At 8:18 p.m., patient P.W. was reported to look pale, with moderate continuous bleeding. The fundus was firm. Respondent administered 800 mcg of rectal Cytotec.[9]

24. Patient P.W. was taken to the operating room (OR) and general anesthesia was administered. Exploration revealed multiple vaginal abrasions near the cervix. These lacerations were the cause of bleeding. These were suture-ligated. A uterine curettage was performed and no products of conception were noted. Avitene and Surgicel were applied, and the estimated blood loss (EBL) noted as 50 cc.

25. At 8:25 p.m., the surgery was completed.

26. At 9:32 p.m., no further bleeding was noted and the patient was transferred to the critical care unit (CCU).

27. Subsequently, another doctor assumed care, a second unit of FFP was transfused, additional units of PRBC's were transfused and 1 ampule of calcium gluconate was administered. Midday on January 22, 2014, Patient P.W. was transferred back to the postpartum floor. She was discharged home the following day with an H/H of 7.9/23.5.

28. Respondent was grossly negligent in his care and treatment of patient P.W. when, prior to operative vaginal delivery, he failed to ensure that patient P.W. met the prerequisites, individually and/or collectively, as follows:

(a) Respondent failed to ensure patient P.W. had a fully dilated cervix;

(b) Respondent failed to estimate or document estimating fetal weight;

(c) Respondent failed to determine or document determining the position of the fetal head, and;

(d) Respondent failed to obtain informed consent from patient P.W.

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[9] Cytotec is the brandname for misoprostol, a medication used to prevent stomach ulcers by protecting the stomach lining and decreasing stomach acid secretion. It is also sometimes used to treat ulcers and to induce labor.

Patient L.N.

29. On or about March 9, 2014, patient L.N. presented to the Garden Grove Hospital in labor at 35 5/7 weeks gestation. She was having contractions every 3 minutes and her cervix was 2 cm dilated. She had a history of a prior cesarean section, and Respondent performed a repeat cesarean section that was reported as uncomplicated. She was delivered of a healthy infant at 10:19 p.m.; this was the requested time of birth by the patient. Respondent later reported that the C-section was easy. At the completion of the C-section, the nurse massaged the uterus and a large gush of blood was observed, about 1000 cc as noted in Respondent's operative report.

30. Respondent was called and ordered an increase in IV Pitocin, administration of intramuscular (IM) Methergine, ordered Hemabate, and placement of 1000 mcg of Cytotec per rectum. Patient L.N.'s estimated blood loss from the caesarian section was 600 cc with an additional 1000 cc EBL from the hemorrhage.

31. Patient L.N.'s preoperative H/H (hemoglobin and hematocrit) had been 11.2/34.8. At 10:55 p.m. her blood pressure was low at 80/53 and Respondent ordered a transfusion of 4 units of PRBC's. He placed a Bakri balloon at 11:50 p.m. and filled it with 600 cc.

32. Respondent noted that he had spoken with patient L.N. and her mother who indicated a desire to retain her uterus, and said she had also had a history of postpartum hemorrhage treated with transfusion in her prior pregnancy.

33. At 11:20 p.m., Respondent felt that patient L.N. had responded to the treatment with no further bleeding and her blood pressure had improved.

34. During the time of transfusion, patient L.N.'s vitals were as follows:

- 11:18 p.m.: BP 85/32, HR 133, 1st unit PRBC transfused;
- 11:33 p.m.: BP 101/60, HR 115;
- 11:45 p.m.: BP 100/72, HR 120, 2nd unit PRBC transfused;
- 11:54 p.m.: BP 109/59, HR 127, 3rd unit PRBC transfused;
- 12:08 a.m. (March 10, 2014): BP 102/60, HR 130, 4th unit PRBC transfused;
- 12:16 a.m.: BP 100/62, HR 148.

35. While the transfusions were being given, her H/H from 11:30 p.m. returned at

6.7/19.9, and the DIC labs at that time were normal. These labs were drawn prior to the blood transfusion. Following the transfusion in the operating room, patient L.N.'s blood pressure was stable, yet she remained tachycardic during this time.

36. After the blood transfusion, at 12:32 a.m., patient L.N. was transferred to the intensive care unit for observation. Respondent later stated that at this point, her blood pressure was stable though she was tachycardic. The Bakri balloon was dislodged during transport, and Dr. W., the assistant surgeon, called Respondent who came and reinserted the balloon at 12:46 a.m., filled it with 600 cc, and packed the vagina. Respondent later stated that at that time, patient L.N. was not bleeding, her uterus was firm and there was no blood in the collection bag of the Bakri balloon. Patient L.N. was awake and talking, no bleeding was noted, her BP was 100/60, and her HR was 120. Respondent later stated that at 12:30 a.m., he had ordered a CBC and DIC panel after the transfusion but the order was cancelled by the nurse. Respondent left the hospital at 12:52 a.m.

37. At this time, there was a lack of appropriate follow-up of vital signs and labs to properly dictate further care. The underlying cause of patient L.N.'s post-partum hemorrhage was not appropriately assessed and addressed.[10] Respondent did not assess coagulopathy and appropriate replacement or consultation or activation of a hemorrhage protocol did not occur. Respondent treated patient L.N. for uterine atony with uterotonic agents and a Bakri balloon. Respondent did not explicitly document atony in the medical record. Respondent noted in the medical record that the gush of blood postpartum was estimated at 1000 cc but did not reference any additional blood loss. Respondent later stated that he expected patient L.N.'s hemoglobin to increase above 10. Respondent's later dictated discharge summary noted the cause of DIC was amniotic fluid embolism and post-partum hemorrhage (PPH) although there was no suspicion for amniotic fluid embolism prior to, during or after delivery. Respondent later stated that because patient L.N. was not bleeding vaginally, he felt her bleeding was controlled, and did not consider intraperitoneal bleeding.[11]

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[10] In the setting of post-cesarean section hemorrhage, uterine atony, surgical bleeding, and coagulopathy must all be considered.

[11] When hypotension occurs in the face of transfusion or the rise in the H/H is subadequate in the post-operative patient, intraperitoneal bleeding and the underestimation of (continued...)

38. Respondent later stated that before he left the hospital, Dr. K., the anesthesiologist, had spoken with Dr. H., the ICU physician. Respondent assumed that Dr. H., was taking over care of patient L.N.[12] Respondent did not speak with Dr. H., before leaving or delineate responsibility. Respondent did not leave any written orders regarding physician responsibility or notification regarding vitals, lab results, or other parameters. Although he believed that Dr. H. was the responsible physician, Respondent later stated that he expected that the nurses would call him if patient L.N.'s H/H was not normal. Respondent did not directly communicate with the nursing staff before leaving.

39. On or about March 10, 2014 at 1:00 a.m., patient L.N. became hypotensive, with a BP of 90/37, and over the next several hours her condition further deteriorated. No physician was notified during this time.

40. Patient L.N.'s vital signs during this time were as follows:

- 1:00 a.m.: BP 75/46 (per Respondent's interview 90/30), HR 141, patient lethargic, 1 unit FFP transfused;
- 1:20 a.m.: BP 80/29, HR 146, patient lethargic;
- 1:40 a.m. BP 98/11, HR 145, patient lethargic, 2nd unit FFP transfused;
- 2:15 a.m. BP 76/53, HR 168, patient lethargic.

41. At 3:13 a.m., patient L.N. became bradycardic with a heart rate of 44 bpm. At 3:14 a.m., a code blue was called. Respondent was called at 3:20 a.m. and arrived at 3:34 a.m. Patient L.N. was intubated by the ER physician, who placed a central line.

42. Patient L.N.'s labs from 3:05 a.m. showed a Hb 4.6, HCT 13.6, platelets 96, PT 10.9, PTI 42. A transfusion of PRBC's and FFP was begun per the ER physician's recommendations, and another physician, Dr. A., was consulted for transfusion. Patient L.N. received Levophed for

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(...continued)
blood loss should be considered. Intraperitoneal bleeding refers to bleeding in the fluid-filled gap between the wall of the abdomen and the organs contained in the abdomen.

[12] Dr. H reported having received a call from the anesthesiologist, Dr. K., shortly after midnight with the suggestion that the patient may need to be taken back to the OR for a hysterectomy. Dr. H did not speak with Respondent directly. Dr. H. later asserted that he was not the physician responsible for patient L.N.'s care between midnight and 4 a.m.

blood pressure support. Patient L.N.'s PTI returned at > 150, consistent with DIC. Dr. A's dictated consultation notes a consumptive coagulopathy due to persistent vaginal bleeding, with exploratory laparotomy recommended to control bleeding and product replacement with PRBC, platelets, cryoprecipitate, FFP, and possible Amicar, an agent to control bleeding. It is unclear how and when this assessment was communicated at the time, as the note was dictated at a later date on March 14, 2014.

43. At or around 4:00 a.m., the ICU physician arrived. At 4:30 a.m., he noted ongoing vaginal bleeding. He discussed the situation with Respondent who felt patient L.N. was not stable enough to go to the OR for a hysterectomy. Respondent ordered uterine artery embolization, and patient L.N. was sent to interventional radiology for this procedure, however this was not completed since at 10:00 a.m. the patient suffered a second code blue. At that point Respondent decided to perform a hysterectomy. Respondent noted that there was still some oozing around the Bakri balloon and he performed a supracervical abdominal hysterectomy. Respondent's dictated operative report noted the procedure to be uncomplicated with an EBL of 300 ml. No active bleeding had been noted at the time of the procedure, only serosanguineous fluid. During her ICU stay, patient L.N. received a total of 22 units of PRBC's, 9 units of FFP, 2 units of platelets, and 2 units of cryoprecipitate.

44. On or about 6:00 p.m., patient developed abdominal distension with concern for compartment syndrome. A bedside decompression was performed by Dr. A-2, a hematologist, confirming the diagnosis. Decompression was performed and 1200 ml of serosanguineous fluid was noted in the abdominal cavity at the time of the procedure. Dr. A-2 later took patient back to the OR for reevaluation due to an elevated LDH and acute renal failure and concern for possible ischemic bowel. This was confirmed at the time of surgery; an exploratory laparotomy, right hemicolectomy, enterectomy of the ileum and multiple enteroenterostomies and control of pelvic bleeding was performed.

45. Patient L.N. developed renal failure and was started on dialysis. Due to her extremely poor prognosis with persistent shock and anoxic encephalopathy, her family withdrew life support and she passed away at 11:16 p.m. on March 14, 2014. The autopsy reported the cause of death as

DIC and multi-organ failure.

46. Subsequent to March 2014, Respondent has failed to take steps to ensure prompt consultation with subspecialists and experts in critical situations that are beyond the scope of his usual practice; failed to shift his practice in any other way that might help improve patient safety such as: to stay in the hospital to facilitate ongoing assessment of a patient who has suffered a major complication; to assess blood loss; to activate transfusion protocols for factor replacement, or; to ensure that when there is ongoing bleeding in an unstable patient, a hysterectomy is performed without delay.

47. Respondent was grossly negligent in the care and treatment of patient L.N. in that he failed to properly manage an unstable patient.

48. Respondent was grossly negligent when, despite a maternal death, he failed to assess potential changes in his practice procedures to improve patient safety.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

49. Respondent Long-Dei Liu, M.D. is subject to disciplinary action under Code section 2234, subdivision (c), in that he was negligent in his care and treatment of four patients. The circumstances are as follows:

Patient P.W.

50. Paragraphs 9 through 27 above are incorporated herein as if fully set forth.

51. Respondent was negligent in his care and treatment of patient P.W. when, prior to operative vaginal delivery, he failed to ensure that patient P.W. met the prerequisites, individually and/or collectively, as follows:

(a) Respondent failed to ensure patient P.W. had a fully dilated cervix;

(b) Respondent failed to estimate or document estimating fetal weight;

(c) Respondent failed to determine or document determining the position of the fetal head;

(d) Respondent failed to obtain informed consent from patient P.W.

52. Respondent was negligent in his care and treatment of patient P.W. when he failed to

assess glucose control in the face of gestational diabetes, individually or collectively, when he failed to:

(a) perform glucose surveillance during the pregnancy;

(b) estimate fetal weight during the antenatal course by ultrasound nor clinical examination;

(c) estimate fetal weight at the time of hospital admission.

53. Respondent was negligent in his care and treatment of patient P.W. when he failed to appropriately assess and treat the cause of postpartum hemorrhage.

Patient L.N.

Paragraphs 29 through 46 are incorporated herein as if fully set forth.

54. Respondent was negligent in the care and treatment of patient L.N. in that he failed to properly manage an unstable patient.

55. Respondent was negligent when, despite a maternal death, he failed to assess potential changes in his practice procedures to improve patient safety.

56. Respondent was negligent in his care and treatment of patient L.N. in that he inappropriately assessed and managed her postpartum hemorrhage.

57. Respondent was negligent in his care and treatment of patient L.N. in that he assumed he had transferred care of patient L.N. even though he had had no direct communication with other physicians or nursing staff.

Patient X.H.

58. Patient X.H. received late prenatal care from Respondent during her first pregnancy beginning at 20 weeks gestation. On or about May 6, 2014, at 24 weeks gestation, Respondent performed group B Strep testing. An ultrasound at 26 weeks gestation showed a fetus with appropriate growth for the gestational age. At 39 weeks gestation, the recorded fundal height was 35 c.m., which would normally raise suspicion for fetal growth restriction. Nevertheless, Respondent later stated that he had felt the baby was large. No clinical estimated fetal weight was noted nor was an ultrasound ordered.

59. At 39 3/7 weeks gestation, on or about August 18, 2014 at 9:31 p.m., patient X.H.

had premature rupture of the membranes and arrived at the hospital. Per the nurse, her cervical exam on admission was fingertip dilated, 80% effaced and -3 station. Respondent ordered Pitocin administration.

60. When Respondent assessed the patient the next morning at 10:00 a.m., the head remained high and the cervix was still fingertip. He felt the patient's pelvis was small, the estimated weight of the baby was big (8 pounds) and the head was high. He diagnosed cephalopelvic disproportion and recommended delivery by cesarean section.

61. Respondent was negligent when he performed group B Strep screening at approximately 24 weeks gestation rather than between 35-37 weeks gestation.

62. Respondent was negligent when he failed to estimate fetal weight despite lagging fundal height at 39 weeks gestation.

Patient K.B.

63. On or about July 15, 2014, Respondent's patient K.B., a pregnant 31 year-old woman at 38 weeks gestation, presented in early labor to Garden Grove Hospital and Medical Center with contractions every two to four minutes. She was dilated 3 cm at presentation. An amniotomy was performed, a fetal scalp electrode and intrauterine pressure catheter were placed, and a fetal bradycardia to 80 bpm was noted at 11:10 p.m. Oxygen and repositioning did not relieve the bradycardia, and there was delivery by urgent cesarean section at 11:33 p.m. of a female infant with a weight of 2750 grams, Apgar's 3 and 9, a nuchal cord times one. The arterial cord pH was 7.056 and base excess -12.8, and the venous cord pH was 7.193 and base excess -10.9. The infant was admitted to the Intensive Care Unit for slow transition and possible sepsis; a work-up was done and antibiotics were started.

64. Respondent had treated and cared for patient K.B. during her pregnancy. At 7 weeks gestation, on or around December 13, 2013, Respondent performed group B strep screening. The following fundal heights were recorded: at 29 weeks, 25 c.m.; at 36 weeks, 32 c.m.; at 37 weeks, 33 c.m.; at 38 weeks, 33 c.m. A risk factor for fetal growth restriction was present due to patient K.B. smoking during her pregnancy. Respondent failed to assess patient K.B. for fetal growth restriction.

65. Respondent was negligent in the care and treatment of patient K.B. when he performed group B Strep screening at approximately 7 weeks gestation rather than between 35-37 weeks gestation.

66. Respondent was negligent in the care and treatment of patient K.B when he failed to assess for fetal growth restriction.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

67. Respondent Long-Dei Liu, M.D. is subject to disciplinary action under Code section 2234, subdivision (d), in that he demonstrated incompetence in his care and treatment of patient L.N. The circumstances are as follows:

68. Paragraphs 29 through 46 above are incorporated herein as if fully set forth.

69. Respondent failed to understand the possibility of consumptive coagulopathy in patient L.N. He failed to assess coagulopathy, to obtain appropriate replacement of coagulation factors and/or platelets or to activate a hemorrhage protocol. Respondent documented in his dictated discharge summary notes that the cause of DIC was amniotic embolism and PPH, though there was no suspicion for amniotic fluid embolism before, during or after delivery.

70. Respondent failed to understand the possibility of intraperitoneal bleeding in patient L.N. after delivery when she was not bleeding vaginally. Respondent failed to understand that in the post-operative patient, when hypotension occurs in the face of transfusion or the rise in the H/H is subadequate, intraperitoneal bleeding should be considered and underestimation of blood loss should also be considered.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 36134, issued to Long-Dei Liu, M.D.;

2. Revoking, suspending or denying approval of Long-Dei Liu, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Long-Dei Liu, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: March 15, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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